WENATCHEE VALLEY COLLEGE

**SHARED LEAVE REQUEST FORM**

Eligible employees are entitled to request shared leave in accordance with [RCW 41.04.665](http://apps.leg.wa.gov/RCW/default.aspx?cite=41.04.665) and outlined in WVC shared leave policy [500.375](https://commons.wvc.edu/hr/pp/500/Shared%20Leave.aspx) and procedure [1500.375](https://commons.wvc.edu/hr/pp/500/Shared%20Leave.aspx).

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| **REQUESTOR’S INFORMATION** | | | |
| Last Name: | First Name: | Middle Initial: | Hours/Work Schedule: |
| Department: | Job Title: | Employee Type (classified, exempt, etc.): | |
| An employee cannot use shared leave for the same time period he/she qualifies for time loss compensation. Is this request related to a job injury or illness?  Yes  No If yes, is your time-loss claim approved?  Yes  No | | | |

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| **QUALIFYING REASON** (select one): | | **VERIFICATION REQUIREMENT:** |
|  | I suffer from an extraordinary or severe illness, injury, impairment, or physical or mental condition. A “severe or extraordinary condition,” is defined as **serious or extreme and/or life threatening**, as verified by a licensed physician or health care practitioner. **Examples are: cancer, heart attack, stroke, major surgery, severe mental health conditions.** | *If this reason is selected, along with this request, submit the Shared Leave Medical Certificate, completed by a licensed physician or health care practitioner, verifying the* ***severe or extraordinary nature and expected duration of the condition****.* |
|  | I am needed to care for a relative/household member who suffers from an extraordinary or severe illness, injury, impairment, or physical or mental condition. A “severe or extraordinary condition,” is defined as **serious or extreme and/or life threatening.** | *In addition to submitting the shared leave medical certification, explain why**your absence during your regular working hours is necessary* ***for the person’s care****:* |
|  | I have been called to service in the uniformed services. | *For the purpose of participating in the shared leave program, a copy of your military orders verifying your required absence must accompany your request.* |
|  | I have volunteered with a governmental agency or a nonprofit organization when a state of emergency has been declared within the United States. | *Proof of acceptance of your offer to volunteer is required.* |
|  | I am a victim of domestic violence, sexual assault, or stalking as defined in [RCW 41.04.655](http://apps.leg.wa.gov/RCW/default.aspx?cite=41.04.655). | *Also submit a police report, your own written statement, court order, or a statement from your attorney, clergy, medical professional or advocate, etc.* |

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| If approved to participate in the shared leave program, human resources will send an email on my behalf requesting leave donations.  I wish to remain anonymous in the email.  I request that my name be **published** in the email. | |
| I request approval to participate in the shared leave program for the reason selected above. My condition/situation will likely cause me, or has caused me, to take leave without pay or terminate my employment. My absence has depleted or will shortly deplete all of my available leave. I understand that any donated leave may only be used by me **for the reason specified on the shared leave medical certification**. | |
| Date | Signature |

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| Appropriate supporting documentation is attached or being faxed by my healthcare provider?  Yes  No | | Type of leave needed:  Intermittent  Continuous | Anticipated Start Date | | Approximate End Date |
| Date | Print Name | | | Signature | |

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| ***For Use by Human Resources:***  L & I? Yes  No Medical Cert. Received on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Eligible for Optional LTD? Yes No LTD Waiting Period: \_\_\_\_\_\_\_ days Military Orders Received on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date LTD Benefits Begin: \_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Use of Shared Leave: \_\_\_\_\_\_\_ days  Request  Approved  Denied  If denied, explain reason:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HR Representative Signature Date |

Original: Medical File