Application to Receive Shared Leave

Updated: May, 2011

Please complete this form to request certification of eligibility to receive shared leave from fellow UI employees or the general Shared Leave Pool. An employee's representative may submit this application on behalf of the employee if the employee is unable to do so. FSH 3710, K

Return the completed form to Payroll and Benefit Services:
Campus Zip: 4332 / Email: benefits@uidaho.edu / Fax: 208-885-3330

Name:	**Vandal Number or SSN:**	**Department:**
Phone Number: Work: Home:	**Email:** Work: Home:	**Emergency contact:** Name: Phone #:

I am requesting shared leave for:

☐ my own serious illness or injury

☐ my need to care for an immediate family member* who has a serious illness or injury

Name of person: _____ Relationship to you: _____(be specific)

* *Please see the FSH 3710, A-3 for the University of Idaho definition of an "immediate family member"*

Last Day of Work Before Any Leave Begins:	**I have or will file for:** ☐ FMLA ☐ Short-term Disability ☐ Workers' Compensation

I have attached a certificate from a licensed health care provider that describes the illness, injury, impairment, physical or mental condition and the approximate duration of the condition. This required certificate is dated and signed by said provider. I consent to allow the Shared Leave administrator to follow-up with the health care provider if necessary. *If you are also applying for FMLA, the same medical documentation can be used for both the FMLA application and the Shared Leave application.*

I authorize the release of my *name only* in order to receive a direct donation from a fellow UI employee. This information will only be released when a fellow UI employee is limited to a direct donation.

☐ Yes

☐ No

Employee Signature: _____ **Date:** _____

An employee's representative can complete this form on behalf of the employee if the employee is unable to so. If you are the employee's representative, please complete this section.

Name of representative: _____

Human Resource Services Only

Date completed:	EE DOH:	Hourly rate:

Annual Leave Balance:	as of _____ = _____hrs	Eligible for STD:	☐ Yes ☐No as of _____
Sick Leave Balance:	as of _____ = _____hrs	Eligible for LTD:	☐ Yes ☐No as of _____
Comp Time Balance:	as of _____ = _____hrs	Eligible for WC:	☐ Yes ☐No as of _____

Approved for SHL: ☐ Yes ☐ No	Total Dollar Amt:	Total Days: