Application to Receive Shared Leave

Updated: August 2016

Employee: Please complete this completed application with supporting documentation 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. Recipients of Shared Leave have an expectation to return to work following leave and use of Shared Leave and failure to do so may be subject to repayment of benefits and compensation of shared leave benefits. See FSH3710 for specific information. Return the completed form to Benefit Services: Campus Zip: 4332 / Email: benefits@uidaho.edu / Fax: 208-885-3330

Name:	**Vandal Number:**	**Department:**
Phone Number: Work: Cell:	**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 for the University of Idaho definition of an "immediate family member"

Last Day of Work Before Any Leave Begins:	**Expected Duration of Leave:** ______________________ **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 requesting information for 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: _____________ Date: ________ Sick Leave Balance: _____________ Date: __________ Comp Time Balance: _____________ Date: __________	Eligible for STD: ☐ Yes ☐ No Date ______________ Eligible for LTD: ☐ Yes ☐ No Date ______________ Eligible for WC: ☐ Yes ☐ No Date ______________

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