**INSTRUCTIONS:** Use this form to request to receive donated shared leave for one of the reasons specified below.

**DISTRIBUTION:** Forward the completed form to the HR Operations office that serves your unit. See <http://hr.uw.edu/ops/leaves/shared-leave/> for information and definitions relating to Shared Leave.

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| PART 1: RECIPIENT (The employee requesting to be the recipient of shared leave fills out this section.) |
| Check the reason you are requesting shared leave and provide any additional information requested:1. [ ]  I have a “severe or extraordinary illness” or injury[[1]](#footnote-2). (If information about your condition is not currently on file in Human Resources, you will be asked to have your health care provider complete and submit a certification form.)
2. How long do you expect to be off work (if known): From       Until
3. Do you expect to use shared leave intermittently or on a reduced schedule? [ ]  Yes [ ]  No
4. If you answered yes to the previous question, please describe your anticipated work schedule and the length of time the schedule will need to be in place:
5. [ ]  I must provide care for a close family or household member who has a “severe or extraordinary illness” or injury. (If information about your family/household member’s condition is not currently on file in Human Resource, you will be asked to have your health care provider complete and submit a certification form.)

 Please identify and specify your relationship to the person for whom you are providing care: 1. Name of person you are caring for:
2. Relationship to the person you are caring for:

[ ]  Parent  [ ]  Child  [ ]  Spouse [ ]  Domestic Partner [ ]  Sibling  [ ]  Grandparent[ ]  Household member  [ ]  Parent-in-law  [ ]  Other – Please specify     1. How long do you expect to be off work (if known)       Until
2. Do you expect to use shared leave intermittently or on a reduced schedule? [ ]  Yes [ ]  No
3. If you answered yes to the previous question, please describe your anticipated work schedule and the length of time the schedule will need to be in place:
4. [ ]  I am temporarily disabled because of pregnancy disability[[2]](#footnote-3) or have a newborn, adoptive, or foster child and need parental leave[[3]](#footnote-4). (If information about your condition is not currently on file in Human Resources, you will be asked to have your health care provider complete and submit a certification form.)
5. If known, how long do you expect to be off work? From:       Until:
6. Do you expect to use shared leave intermittently or on a reduced schedule? [ ]  Yes [ ]  No
7. If you answered yes to the previous question, please describe your anticipated work schedule and the length of time the schedule will need to be in place:
8. Please confirm the following by checking the box next to the statement. If the statement is not accurate for you, it means that you are not currently eligible to receive shared leave donations.

**[ ]** Due to the reasons provided above, I will have to take leave without pay or terminate employment because I do not have sufficient paid leave to cover my absence from work. |
| Requestor Name (Last, First, MI):      | EID:       | Requestor Phone:      |
| Employment Date:       | Employing Department:       | UW Box Number:       |
| Requestor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:       |

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| PART 2: DEPARTMENT (The department of the employee requesting to be the recipient of shared leave fills out this section.) |
| If you approve your employee’s request, complete this section and then send the full form to your HR Operations office for review and processing. |
| Current Employee Balances: Vacation Leave:       Sick Leave:       Compensatory Time:       Has the employee’s Personal Holiday been used?  [ ]  Yes [ ]  No |
| Administrator or Manager Name:       | UW Box Number:       |
| Please indicate the billing worktags to be credited with shared leave (i.e., Company + Driver Worktag OR Company + Driver + Fund). Only one set of billing worktags is required to complete this section. If splitting across multiple budgets, please provide the additional billing worktags and indicate the distribution percentage. |
| Billing worktags:        | % Distribution:       |
| Billing worktags:        | % Distribution:       |
| Billing worktags:        | % Distribution:       |
| Billing worktags:        | % Distribution:       |
| [ ]  I have reviewed the employee's request to receive shared leave. [ ]  The employee has followed department sick leave use guidelines. |
| Receiving Department Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:       | Phone Number:       |

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| PART 3: HR OPERATIONS OFFICE (HR Operations office completes this section.) |
| [ ]  The above employee is eligible to receive shared leave. The cash value of hours donated by other employees will be converted to shared leave hours to be credited to your department budget. |
| HR Operations Office Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:       |
| Phone Number:       | Shared Leave Start Date:       |

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| HR OPERATIONS CONTACT INFORMATION |
| **Harborview Medical Center** Fax: (206) 598-4610325 Ninth AvenueBox 359715Seattle, WA 98104Or, MedCtrFMLA@uw.edu | **UW Medical Center Montlake & Northwest**Fax: (206) 598-46101959 NE Pacific #BB150Box 356054Seattle, WA 98195Or, MedCtrFMLA@uw.edu |

**HR Operations**: Upon completion, return two copies to the Department indicated (Department copy and Donor copy) and make copies for employee file and shared leave file.

1. A “severe or extraordinary illness” or injury prevents the individual from working and causes great economic and emotional distress to the employee and his/her family . [↑](#footnote-ref-2)
2. Pregnancy disability means a pregnancy-related medical condition or miscarriage. [↑](#footnote-ref-3)
3. Parental leave means leave to bond and care for a newborn child after birth or to bond or care for a child after placement for adoption or foster care. [↑](#footnote-ref-4)