Pierce County

SHARED LEAVE REQUEST FORM

Name	Employee ID Number
Department/Position	Contact Number

☐ **Block of Leave** ☐ **Intermittent Leave**

Leave Begin Date: _____ Duration of Leave: _____

☐ **Self** ☐ **Family Member** (specify relationship): _____

Type of request – please mark all that apply:

☐ Injury Date of Injury: _____ ☐ Work Related

☐ Illness ☐ Treatment

☐ Surgery - Date: _____

☐ Other (briefly describe; please do not provide diagnosis information): _____

_____

IMPORTANT NOTES:

A statement from your physician or medical provider attesting to the nature of the medical condition, illness, injury or impairment; including prognosis for recovery and estimated length of absence MUST be provided directly to the Human Resources Department as per policy Section 3.70.070, Item A.

If you are eligible for and collect Worker's Compensation benefits, you are not eligible for this program.

Please be advised that shared sick leave donations do not qualify as reportable compensation towards service credit for retirement. This is in accordance with WAC 415-108-468 (3) (b).

I acknowledge that it is my responsibility to review and become familiar with and abide by the Shared Sick Leave policy. My signature below authorizes the Human Resources Department to publish my name along with the request for sick leave donations.

Signature	**Date**

Department Director

APPROVED [ ] DISAPPROVED [ ] UNABLE TO DETERMINE [ ]	If disapproved, explain:
Signature	Date

Human Resources Director

APPROVED [ ] DISAPPROVED [ ]	If disapproved, explain:
Signature	Date