Columbia Basin College
SHARED LEAVE REQUEST
HUMAN RESOURCES OFFICE

INSTRUCTIONS: Please type or print clearly and forward to:
Columbia Basin College
Human Resources Office / A2

Receiving Employee

To request donated leave from other state employee(s):

1) Complete the receiving employee's section of this form, and

2) Send the required medical certification to your Human Resources Office, MS-A2.

To be eligible to receive shared leave you must meet the following criteria:

1) Be a permanent Columbia Basin College employee, or other state employee who accrues leave, and

2) You or your relative, or household member as defined by Chapter 357-31 WAC must have a severe or extraordinary illness or injury that has caused or is likely to cause you to take leave without pay or terminate employment, or

3) You must have been called in the uniformed services of the United States which is likely to cause you to take leave without pay or terminate employment.

If necessary, you may designate a representative to make this request on your behalf.

Receiving Employee Name (Last, First, MI)	Employee SID Number
Employment Date	Employing Department
If applicable, name of ill person you provide care to:	Relationship to You

I certify that I meet the above eligibility requirements and have provided either: A completed medical certificate (see below) or; documentation that I have been called to duty in one of the uniformed services of the United States.

Employee Signature_____Date_____

Medical Certification

I certify that the above-named employee suffers from, or has a relative or household member suffering from an illness, injury, impairment, or physical or mental condition which is of an extraordinary or severe nature. "Severe" or "extraordinary" condition is defined as serious or extreme and/or life threatening. Please provide the employee's required absence (type of absence: intermittent, long-term, etc.), description of the medical problem, and the expected date of return to work status.

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_____ _____/_____/_____
Signature of Health Care Provider Date

Human Resources Office

The above employee ☐ ***is*** ☐ ***is not*** eligible to receive shared leave.

HR Office Approval/ Denial

_____ _____/_____/_____
Signature Date

Notes:

Shared Leave Begins Date

_____/_____/_____
Month Date Year

April 2007