Application to Receive Voluntary Shared Leave

Instructions: Please complete the information below and submit to the Human Resources Department. Also, attach a Family and Medical Leave Certification from your physician documenting the need for leave and the period of absence.

Employee Name _____

Department _____

Annual Leave Balance _____ As of Date: _____

Sick Leave Balance _____ As of Date: _____

TOTAL NUMBER OF LEAVE HOURS REQUESTED _____
(Maximum of 480 hours of Shared Leave per Calendar Year)

Employee Statement:
"This is to request participation in the County of Harnett's Shared Leave Program. I and/or a member of my immediate family have a medical condition as specified in the attached physician's statement that is resulting in my absence from work. This is not an elective surgery, I am not receiving Worker's Compensation benefits nor do I plan to seek subrogation from a third party for the leave time. All of my Sick Leave and Annual Leave has been exhausted and I am requesting donated Shared Leave hours as specified above."

____ I authorize the Human Resources Department to release information indicating that I or a member of my immediate family have a serious medical condition which would otherwise be confidential personnel record information and that I desire Shared Leave donations.

____ I do not authorize the Human Resources Department to release my name or medical information indicating that I have a serious medical condition. I understand that although I may be eligible for Shared Leave, by limiting the information that is released, willingness of my co-workers to donate leave to a blind request may be reduced.

_____
Employee's Signature and Date

Department Head Comments:

_____

_____

_____
Department Head Signature and Date