APPLICATION TO RECEIVE SHARED LEAVE

PART 1 – TO BE COMPLETED BY EMPLOYEE

I am submitting this application for Shared Leave because I have the following qualifying reason:

☐ I suffer from, or have a relative or household member suffering from, an illness, injury, or physical or mental condition that is of an extraordinary or severe nature.

☐ I have been called to service in the uniformed services.

☐ I am volunteering with a government agency or non-profit organization during a state of emergency in the United States declared by the federal or any state government to assist in responding to the emergency or its aftermath.

☐ I am a victim of domestic violence, sexual assault, or stalking as defined in RCW 41.04.655.

My absence is verified as necessary by a licensed medical or mental health provider, by military orders, by the government agency or non-profit organization accepting my offer of volunteer services, or by another credible source if my request is a result of domestic violence, sexual assault, or stalking. The necessary documentation has been attached to this application.

☐ If approved, I would like an email to be sent to the campus community notifying them of my application and eligibility to receive shared leave. I understand the reason for my request will remain confidential.

SIGNATURE OF EMPLOYEE ___________________________ DATE __________ PHONE # ___________________________

PRINTED NAME ___________________________ SID # ___________________________

NAME AND RELATIONSHIP OF PERSON YOU PROVIDE CARE TO (IF APPLICABLE)

PART 2 – TO BE COMPLETED BY THE HUMAN RESOURCE DEPARTMENT

This application has been reviewed. Other options have been considered to keep the employee in pay status, but are not feasible. The employee has followed the appropriate Walla Walla Community College leave procedures and is not receiving Labor and Industries (L&I) time loss or other disability payments. The reasons for this request are justified.

☐ This request for shared leave is approved through ___________________________

☐ This request for shared leave is approved conditionally as follows: ___________________________

________________________________________________________________________________________

________________________________________________________________________________________

HUMAN RESOURCE DIRECTOR ___________________________ DATE ___________________________

Original – Employee Occupational Health Record  Copies – Employee and Payroll Department