

Shared Leave Application

Employee Certification

Employee Name (print): _____ WWU Employee ID# _____

Relationship of person with medical condition (if not employee): _____

Please answer the following questions:

- 1) I give permission for Human Resources to communicate my request for donations through the following means:
 FAST Department Email Bargaining Unit Representative
- 2) I give permission to use my name (if no, “anonymous” will be used): Yes No
- 3) I have received shared leave donations while employed by another WA state agency or higher ed institution:
 Yes No
If yes, indicate name of state agency or higher ed institution: _____
- 4) I am requesting leave for the following time period: From (date) _____ To (date) _____
- 5) I am requesting the following type of leave:
 Full-time Reduced Schedule Intermittent Leave
- 6) I am applying for shared leave due to the following reason:
 My own, or a family member’s illness. (*Please have a healthcare provider complete the Physician Certification below.*)
 I have been called to military service. (*Please attach a copy of military orders.*)
 I have been accepted as a volunteer for services needed during a currently declared state of emergency within the United States. (*Please attach a statement of volunteer assignment from the government agency or non-profit organization that you will be assisting.*)
 I certify I am a victim of domestic violence, sexual assault, or stalking. (*Please submit with a completed Domestic Violence Leave Application if not already done.*)

Employee’s signature: _____ Date _____

Physician Certification – For completion by Health Care Provider Only (when applicable)

I certify that the employee listed on this form is suffering from or has a relative or household member suffering from, an extraordinary or severe illness (serious or extreme and/or life threatening), injury, impairment, or physical or mental condition. The person’s condition will remain in the “serious or extreme and/or life threatening” status for the following duration (which may or may not include the entire recovery period):

From (date) _____ To (date) _____

Physician’s Name (Print): _____ Type of Practice: _____

Physician’s Signature: _____ Date: _____

HR Approval

Applicable leave balance is or may be depleted Yes No Meets eligibility requirements Yes No

If no, reason not eligible: _____

HR signature: _____ Date: _____