Northshore
School District

5406 F-1

APPLICATION TO RECEIVE SHARED LEAVE

Name (typed or printed): ______________________ Position: ________________________________

Location: ________________________________

I am making application to receive shared leave under the Northshore School District #417 Leave Sharing Program. I understand that in order to participate in this program, the following must be true:

1. I must be suffering from or have a relative or household member suffering from an extraordinary or severe illness, injury, impairment, physical or mental condition, or have been called to service in the uniformed services, which has caused or is likely to cause me to take leave without pay or to terminate my employment.

   WAC 392-126-065 defines extraordinary or severe as "serious, extreme and/or life threatening."

2. I must have abided by the District's policies and procedures regarding sick leave.
3. I must exhaust all forms of paid leave available to me prior to receiving and using donated leave.
4. I must provide documentation from a licensed physician or authorized health care practitioner verifying the severe or extraordinary nature and expected duration of the condition.

   ☐ Physician's documentation is attached.

5. My condition will soon cause me to go on leave without pay or to terminate District employment.

Employee Signature: ____________________________________ Date: ____________________

☐ **Approved** ☐ **Disapproved**

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Signature: ____________________________________ Date: ____________________
Human Resources Administrator

SHARED LEAVE MEDICAL DOCUMENTATION

To Be Completed By Employee

I understand that in order to participate in the Northshore School District #417 Leave Sharing Program, I must provide documentation from a licensed physician or authorized health care practitioner verifying the severe or extraordinary nature and expected duration of the condition.

I hereby authorize you to release the information requested to Northshore School District #417.

Employee Signature:____Date: _________________________________

To Be Completed By Physician/Health Care Provider

In order to receive shared leave under state law, the employee must be suffering from or have a relative or household member suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition. WAC 392-126-065 defines extraordinary or severe as "serious, extreme and/or life threatening."

Name of Patient:____Date patient was treated:_________________

Does the patient have an illness, injury, impairment, physical or mental condition that is **serious, extreme, and/or life-threatening**?

☐ **Yes** ☐ **No**

Description of the health condition:

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____

Expected Duration of Condition:____

My signature below attests that the condition is of a severe or extraordinary nature as defined in WAC 392-126-065.

Physician's Signature:____Date:__________________________________

Physician's Name:____Phone:_________________________________

Address:____

Return completed forms to Northshore School District Human Resources:
3330 Monte Villa Parkway, Bothell WA 98021
Fax: 425-408-7625