



Aberdeen School District No. 5

Human Resources Department
216 North G Street, Aberdeen WA 98520
Phone: 360.538.2000 | Fax: 360.538.2014

Shared Leave Request Form

Aberdeen School District employees may participate in the Shared Leave Program developed within the guidelines of WAC 357-31-390. Aberdeen School District Policy 5406 requires all requests for the consideration of shared leave is made by the employee (or legal guardian) and attested to by a licensed physician or authorized health care authority prior to such leave being taken. ***Return completed form to the Aberdeen School District Human Resources Department.***

Shared leave may be requested if the requesting employee has been called to service in the uniformed services, or 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 ***as defined by WAC 357-31-390***; and which has caused, or is likely to cause, the employee to:

- go on leave without pay; or
- terminate employment; or
- deplete his/her paid leave reserves; or
- be ineligible for benefits under RCW 51.32 (Industrial Insurance).

Employee Statement

Employee Name: _____

Date: _____

____ I request the use of shared leave because I have been called to service in the uniformed services.

____ I request the use of shared leave for the medical event(s) described in the Physician's Statement (see reverse). The request is for an extraordinary or severe illness, injury, impairment, or physical or mental condition as defined by WAC 357-31-390.

1. Person suffering medical event:

- Employee: Yes _____ No _____
- Relative: (List) _____
- Household Member: (List) _____

2. I expect Workers' Compensation Benefits: Yes _____ No _____

3. I expect Short or Long Term Disability Benefits Yes _____ No _____

4. Amount of shared leave requested _____ hours/days (circle one)

Start date: _____

Anticipated End date: _____

Employee's Signature

Date

**** (See reverse for Physician's Statement) ****

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Physician's Statement

Patient's Name: _____

Date: _____

Please answer the following questions to assist with the determination of eligibility for the criteria defined by WAC 357-31-390.

1. Patient suffered/s from a serious or extreme medical event? Yes _____ No _____
2. Patient suffered/s from a life threatening medical event? Yes _____ No _____

My patient's condition is extraordinary and/or severe (defined by WAC 357-31-390 as serious or extreme and/or life threatening) because:

(Please describe in detail)

Expected Duration: _____

I attest this medical event is of an extraordinary and/or severe nature as described in WAC 357-31-390. *As used in this chapter, extraordinary or severe means serious or extreme and/or life threatening.*

Physician's Printed Name

Signature

Date

Employee must submit both the completed Employee Statement and Physician's Statement to Aberdeen School District Human Resources Department