

Human Resources

Application to Receive Shared Leave

5406 F-1

Name: *(typed or printed)* _____ Employee ID: _____

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:

- ☐ a. suffering from or have a relative or household member suffering from an extraordinary or severe illness, injury, impairment, physical or mental condition; may retain 40 hours annual leave and 40 hours of sick leave. I would like to maintain the following hours in reserve _____ hours annual and _____ hours sick.
- ☐ b. have been called to service in the uniformed services; may retain 40 hours annual leave and 40 hours of paid military leave. I would like to maintain the following hours in reserve _____ hours annual and _____ hours paid military leave.
- ☐ c. have needed skills to assist in responding to a state of emergency or its aftermath declared within the United States by the federal or any state government; may retain 40 hours annual leave. I would like to maintain the following hours in reserve _____ hours annual leave.
- ☐ d. be a victim of domestic violence, sexual assault, or stalking; I would like to maintain the following hours in reserve _____ hours annual leave.
- ☐ e. be a current member of the uniformed services or a veteran and am attending medical appointments or treatments for a service connected injury or disability; may retain 40 hours annual leave and 40 hours of sick leave. I would like to maintain the following hours in reserve _____ hours vacation and _____ hours sick.
- ☐ f. be the spouse of a current member of the uniformed services or a veteran who is attending medical appointments or treatments for a service connected injury or disability and requires assistance while attending appointment or treatment; may retain 40 hours annual leave and 40 hours of sick leave. I would like to maintain the following hours in reserve _____ hours vacation and _____ hours sick.
- ☐ g. need the time for parental leave, for a period up to sixteen weeks after birth or placement; my due date is: _____. Last day of my sixteen-week eligibility is: _____; may retain 40 hours annual leave and 40 hours of sick leave. I would like to maintain the following hours in reserve _____ hours annual and _____ hours sick.
- ☐ h. or sick or temporarily disabled because of pregnancy disability; may retain 40 hours annual leave and 40 hours of sick leave. I would like to maintain the following hours in reserve _____ hours annual and _____ hours sick.

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

- 2. My job is one in which annual vacation and/or sick leave can be used and accrued.
- 3. I am not eligible for time loss compensation.
- 4. I must have abided by the district’s policies and procedures regarding sick leave.
- 5. 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.
- 6. My condition will soon cause me to go on leave without pay or to terminate district employment.

Employee Signature _____ Date _____

☐ Approved ☐ Disapproved

Human Resources Administrator: _____ Date: _____

Human Resources

**SHARED LEAVE MEDICAL DOCUMENTATION -
EXTRAORDINARY OR SEVERE CONDITION**

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: _____

Patient Relationship to Employee: _____

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:

Date Patient was treated: _____

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: _____