Leave Sharing Request

Part I - to be completed by Employee

Note: Under state law shared leave is for use by an employee who is suffering from, or has a relative or household member suffering from, an extraordinary or severe illness, injury, impairment or physical or mental condition; or the employee is a victim of domestic violence, sexual assault, or stalking; the employee has been called to volunteer or uniform service; pregnancy disability or parental leave. Verification of a qualifying medical condition must be provided by a physician and included with the leave sharing application. If the leave reason is non-medical, proof of the qualifying situation must be provided.

Employee Name:_____ Employee ID #: _____

Job Title:_____ School/Program: _____

Reason for request (check one):

- ○ Employee Health condition – **Part II of this form must be completed by Health Care Provider**
- ○ Domestic Violence, sexual assault, or stalking – attach Police report or court order
- ○ Uniform Service – attach a copy of Orders to Report
- ○ Volunteer Service– attach a copy of Service Orders
- ○ Pregnancy Disability – **Part II of this form must be completed by Health Care Provider**
- ○ Parental Leave – attach a copy of birth record, adoption, or foster placement orders
- ○ Family Health condition** – **Part II of this form must be completed by Health Care Provider**

If reason for request is **Family Health Condition, please indicate name of the affected person and relationship to employee:

Name:_____ Relationship: _____

I am requesting authorization to receive shared leave donations under the provisions of RCW 28A.400.380, RCW 41.04.665, WAC Chapter 392-126, and Board Policy 5400. I have read the shared leave requirements and understand that these criteria will be used to determine my eligibility. I understand that I will not receive shared leave donations until I have depleted all but 40 hours of my annual leave and 40 hours of my sick leave reserves. My signature below attests to the accuracy of this application and to my belief that a qualifying condition exists.

- ☐ I am requesting shared leave donations from individual employees/coworkers. I understand the District does not solicit these donations on my behalf.
- ☐ I am requesting shared leave donations from the District wide shared leave pool. I understand donations from the pool are only provided as available.

Employee Signature:_____ Date:_____

Return form to:
Seattle Public Schools MS 33-380
PO Box 34165
Seattle, WA 98124-1165
Fax to: 206-252-0021
Email to: HRLeaves@seattleschools.org

Part II - to be completed by Physician (if required, see "Reason for request" on previous page)

Note: Under state law shared leave is for use by an employee who is suffering from, or has a relative or household member suffering from, an extraordinary or severe illness, injury, impairment or physical or mental condition; or the employee is a victim of domestic violence, sexual assault, or stalking; the employee has been called to volunteer or uniform service; pregnancy disability or parental leave. Verification of a qualifying medical condition must be provided by a physician and included with the leave sharing application. If the leave reason is non-medical, proof of the qualifying situation must be provided.

Name of Patient: _____

Date(s) patient was treated: _____

Do you certify the patient meets at least one of the criteria noted in the paragraph above as an authorized reason to receive shared leave donations?

Yes◯ No◯

Probable duration of condition: _____

Physician's Name: _____ Phone: _____

Address: _____ Fax #: _____

Physician's Signature: _____ Date: _____

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For Office Use Only:

Request Granted ☐ Request Denied ☐

Reviewer Signature _____