

Completing the Shared Leave Request

Instructions for Completing the Form Electronically

This form is designed to be completed in Microsoft Word using the form completion feature. Use the tab key to move from field to field to enter the requested information. If you need to revise text that you have entered you can use your mouse to position your cursor in the field that you need to change.

The individual preparing the form follows these steps:

1. Save the downloaded form to a location where you can find it, if necessary.
2. If the cursor is not already in the first form field, place it there and enter the requested information.
3. Use the tab key to move to the next form field.
4. Upon completion of each field, use the tab key to move to the next form field until all of the relevant electronic fields have been completed.
5. Save the form to a directory where you can access it.
6. Print and sign the form.
7. Obtain Supervisor and Administrator signatures as necessary.
8. Route or process the form as required.

If you have questions about completing this form, please contact your Human Resources Operations office for assistance. Please report any technical problems accessing or completing this form to uwhr@u.washington.edu.

Distribution: Forward to the completed form HR Operations office that serves your unit.

HR OPERATIONS OFFICES	
Harborview Medical Center Medical Centers Human Resources 325 Ninth Avenue Seattle, WA 98104-2499 UW Box 359715 Voice: (206) 744-9220 Fax: (206) 744-9955	Health Sciences Operations D302 Health Sciences UW Box 357250 Voice: (206) 543-9406 Fax: (206) 685-2845
Upper Campus Operations Bloedel Hall, Lower Level Box 354561 Voice: (206) 543-2354 Fax: (206) 685-0636	UW Medical Center Operations BB150 UWMC Box 356054 Voice: (206) 598-6116 Fax: (206) 598-4610

SHARED LEAVE REQUEST Personal, Family or Household Member's Health Condition

INSTRUCTIONS: Use this form to request to receive donated shared leave for one of the reasons specified below.

*See "<http://www.washington.edu/admin/hr/polproc/leave/shared-leave.html>" for information and definitions relating to Shared Leave

Medical Center staff must route the completed form along with a complete copy of requesting employee's current Form 220, Official Record of Hours Worked, Leave and Overtime.)

TO BE COMPLETED BY REQUESTING EMPLOYEE

Check the reason you are requesting shared leave and provide any additional information requested:

1. I have a "severe or extraordinary illness" or injury. If information about your condition is not currently on file in Human Resources, you will be asked to have your health care provider complete and submit a certification form.

How long do you expect to be off work (if known) _____ Until mm/dd/yy

Do you expect to use shared leave intermittently or on a reduced schedule: Yes No

If you answered yes to the previous question, please describe your anticipated work schedule and the length of time the schedule will need to be in place:

2. I have to provide care for a close family or household member who has a "severe or extraordinary illness" or injury. Please identify and specify your relationship to the person for whom you are providing care: (Complete SHARED LEAVE REQUEST PART 2 – NEXT PAGE)

Name of person you are caring for: _____

Relationship to the person you are caring for: Parent Child Spouse Domestic Partner Sibling Grandparent
 Household member Parent-in-law Other – Please

specify _____

How long do you expect to be off work (if known) _____ Until mm/dd/yy

Do you expect to use shared leave intermittently or on a reduced schedule: Yes No

If you answered yes to the previous question, please describe your anticipated work schedule and the length of time the schedule will need to be in place

If information about your family/household member's condition is not currently on file in Human Resources, you will be asked to have your health care provider complete and submit a certification form.

Please confirm the following by checking the box next to the statement. If the statement is not accurate for you, it means that you are not currently eligible to receive shared leave donations.

As a result of the reason I have specified above, I will have to take leave without pay or terminate employment because I do not have sufficient paid leave to cover my absence from work..

Last Name:	First Name:	Middle:	EID:
Employment Date:	Employing Department:	UW Box Number:	

Signature _____ Date _____ Phone Number _____

TO BE COMPLETED BY RECEIVING DEPARTMENT

If you approve your employee's request, complete this form and send it to your HR Operations office for review and processing

Current Employee Balances: Vacation Leave _____ ; Sick Leave _____ ; Compensatory Time _____ ; Personal Holiday used? Yes No

Administrator or Manager: _____ UW Box Number: _____

Budget No. to be Credited with Shared Leave:	% Distribution	Task:	Option:	Project:
Budget No. to be Credited with Shared Leave:	% Distribution	Task:	Option:	Project:
Budget No. to be Credited with Shared Leave:	% Distribution	Task:	Option:	Project:

I have reviewed the employee's request to receive shared leave. The employee has followed department sick leave use guidelines.

Signature _____ Date _____ Phone Number _____

HR OPERATIONS OFFICE

The above employee is eligible to receive shared leave. The cash value of hours donated by other employees will be converted to shared leave hours to be credited to your department budget.

Signature _____ Date _____ Shared Leave Begins Date _____
 Phone Number _____ Month/Date/Year _____

HR Operations: Upon completion, return one copy to Department and make copies for employee file and Shared Leave File