



UK Staff Shared Leave Application Employee Form **CONFIDENTIAL** complete **ONLY** by Employee

Instructions:

All sections in the first three pages of this application must be completed. Incomplete applications will not be considered. The first page should be completed and signed by the employee requesting leave. The second page must be completed by the employee's physician. The third page must be completed and signed by the employee's supervisor. **Completed forms must be returned to Employee Relations, 106 Bosworth Hall, Lexington, KY 40506 Fax: 257-1679.**

Name:	Home address:
Daytime phone number:	Person ID Number:
Other phone number:	Department:
Supervisor name:	Supervisor phone number:
Diagnosis and Prognosis: Please be as detailed as possible:	<p>Is this application related to a health or crisis situation involving (check one): <input type="checkbox"/> yourself OR <input type="checkbox"/> a family member</p> <p>If a family member, please indicate his or her relation to you (e.g., wife, child, parent) _____</p> <p>Number of days of leave requested: _____</p> <p>Is your illness or injury the result of an accident? YES NO If yes, please describe:</p> <p>Have you previously donated any vacation leave to the pool? YES NO</p> <p>Have you previously received vacation leave from the pool? YES NO When? _____</p> <p>Are you eligible for FMLA? YES NO If yes, have you applied?</p> <p>Have you elected short term disability coverage? YES NO</p> <p>If yes, have you utilized all of short term disability coverage? YES NO</p> <p>Are you eligible for, or have you applied for any other benefits such as social security disability, worker's compensation, payments from insurance, or unemployment? YES NO</p> <p>If yes, please describe:</p>
<p>Upon submission of the original or a photocopy of this authorization, I declare I have read the shared leave procedure and the answers given are complete and true to the best of my knowledge.</p> <p>Signature _____ Date _____</p>	

UK Staff Shared Leave Application

Physician Form **CONFIDENTAL** completed **ONLY** by Healthcare Provider

This must be completed by the treating physician concerning the medical condition related to the shared leave application. Incomplete medical documentation will not be considered. **Completed forms must be submitted by the employee or returned to the following address: Employee Relations, 106 Bosworth Hall, Lexington, KY 40506, Fax: 859-257-1679.**

To be completed by employee's or employee family member's physician		
Employee (patient) name:	OR	Employee's Family Member (patient) name:
Patient diagnosis: (Please be as detailed as possible)	Date condition commenced:	
Expected duration of condition:		
If hospitalized, please list dates of hospitalization:		
From _____	To _____	
Specific dates you are recommending the employee or family member be completely off work:		
From (date) _____		
To (date) _____		
Physician information:		
Name (please print) _____ Specialty _____		
Business address _____		
Phone _____		
Signature _____		
Date _____		

UK Staff Shared Leave Application
Supervisor Form CONFIDENTIAL completed ONLY by Supervisor

To be completed by supervisor of the individual who is applying for shared leave benefits. **To be considered, completed form must be returned to Employee Relations, 106 Bosworth Hall, Lexington, KY 40506, Fax: 257-1679 within 3 days.**

To be completed by employee's supervisor:	
Employee name:	Person ID number:
Supervisor name:	Supervisor phone number: Supervisor address: Supervisor e-mail address:

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|---|----------|
| Is this individual employed in a regular position, 0.5 full-time equivalent (FTE) or greater? | YES NO |
| Has this individual successfully completed New Hire Orientation? | YES NO |
| Has this individual suffered a catastrophic illness or injury to himself or herself? | YES NO |
| Has employee applied for FMLA, if eligible: | YES NO |
| Is this individual requesting leave to care for a family member or any other person? | YES NO |
| Has this individual depleted all available paid leaves? | YES NO |
| If yes, what date will the unpaid leave start? _____ | |
| Taking into consideration the employee's work history (length of service, overall performance, attendance history, etc.), do you support this employee being approved for shared leave? | YES NO |

Provide your statement of support or non-support below:

Supervisor signature

Date