Human Resources

UK Staff Shared Leave Application
Employee Form

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, 107 Scovell Hall, 0064, Fax: 257-2493**.

Name:	Home address:
Daytime phone number: Other phone number:	Person ID Number: Department:
Supervisor name:	Supervisor phone number:
Diagnosis and Prognosis: **Please be as detailed as possible:**	Is this application related to a health or crisis situation involving (check one): __ yourself OR __ a family member If a family member, please indicate his or her relation to you (e.g., wife, child, parent) _____ **Number of days of leave requested:**_____ Is your illness or injury the result of an accident? YES NO If yes, please describe: Have you previously donated any vacation leave to the pool? YES NO Have you previously received vacation leave from the pool? YES NO When? _____ Are you eligible for FMLA? YES NO If yes, have you applied? Have you elected short term disability coverage? YES NO If yes, have you utilized all of short term disability coverage? YES NO 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 If yes, please describe:

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.

Signature_____**Date**_____

UK Staff Shared Leave Application
Physician Form

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, 107 Scovell Hall, Lexington, KY 40506-0064, Fax: 859-257-2493**

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

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, 107 Scovell Hall, 0064, Fax: 257-2493 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:

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