

## **Shared Sick Leave Program – Request Form**

Employee Name:	OneUSG ID:
Phone #:	Email:
Department:	Supervisor:
I am requestinghours of Shared Leave under t Program Policy.	he terms specified in the Shared Sick Leave
I hereby acknowledge and certify the following:	
I am an active member of the Shared Sick Lea	ave Program.
<ul> <li>I have submitted a medical certification form or an immediate family member.</li> </ul>	to verify a serious health condition for myself
<ul> <li>I agree that I will notify the Office of Human R Workers Compensation, Short Term or Long- Disability Retirement, etc.) prior to or after I</li> </ul>	• • • • • • • • • • • • • • • • • • • •
<ul> <li>I acknowledge that I have read and understar Shared Sick Leave Program policy.</li> </ul>	nd the program provision as set forth in the
<ul> <li>I understand that documentation of having a am acting on behalf of the employee recipier</li> </ul>	Power of Attorney is required with this form if I nt.
 Date Medical Condition Began	Date Medical Condition is Expected to End
	 Date

**INSTRUCTIONS:** Please complete and return this Shared Sick Leave Request form and the Medical Certification form to benefits@gcsu.edu



FOR USE BY THE OFFICE OF HUMAN RESOURCES	
Type of Request: Initial Request Second	dary Request:
Status of Request: Leave Request Approved	Leave Request Not Approved
Your request for donated leave cannot be accepted d	ue to the following reasons:
Human Resources Signature	Date
If this request is denied and you wish to appeal this d	ecision, submit your appeal along with this notice,

in writing to the Office of Human Resources- Shared Sick Leave Program Administer.