**Employee Certification**

Employee Name (print): ___________________________ WWU ID#: __________________
Relationship of person with medical condition (if not employee): ___________________________

**Please answer the following questions:**

1) I give permission to communicate my request for donations through the following means:
   - [ ] Western Today
   - [ ] Department Email
   - [ ] Bargaining Unit Representative

2) I give permission to use my name (if no, “anonymous” will be used):
   - [ ] Yes
   - [ ] No

3) I have received donations while employed by another WA state agency or higher education institution:
   - [ ] Yes
   - [ ] No
   If yes, name of agency or higher education institution: ___________________________

4) I am requesting leave for the following time period: From (date) _____________ To (date) _____________

5) I am requesting the following type of leave:
   - [ ] Full-time
   - [ ] Reduced Schedule
   - [ ] Intermittent Leave

6) I am applying for shared leave due to the following reason:
   - [ ] My own or a family member’s illness. *(Please have a healthcare provider complete the Physician Certification below.)*
   - [ ] I have been called to military service. *(Please attach a copy of military orders).*
   - [ ] I have been accepted as a volunteer for services needed during a currently declared state of emergency within the United States. *(Please attach a statement of volunteer assignment from the government agency or non-profit organization that you will be assisting.)*
   - [ ] I certify I am a victim of domestic violence, sexual assault, or stalking. *(Please submit with a completed Domestic Violence Leave Application if not already done.)*

Employee’s signature: ___________________________ Date: ______________________

**Physician Certification – For completion by Health Care Provider Only (when applicable)**

I certify that the employee listed on this form is suffering from or has a relative or household member suffering from, an extraordinary or severe illness (serious or extreme and/or life threatening), injury, impairment, or physical or mental condition. The person’s condition will remain in the “serious or extreme and/or life threatening” status for the following duration (which may or may not include the entire recovery period):
From (date) _____________ To (date) __________________

Physician’s Name (Print): ___________________________ Phone #: __________________
Physician’s Signature: ___________________________ Date: ______________________

**HR Approval**

Applicable leave balance is or may be depleted
   - [ ] Yes
   - [ ] No
   ______ % Position Grant Funded

Meets eligibility requirements
   - [ ] Yes
   - [ ] No
   If no, reason not eligible: ___________________________

HR signature: ___________________________ Date: ______________________