

SHARED LEAVE APPLICATION

Mail: 516 High Street, MS 9054 /Location: Humanities, 2nd floor Bellingham, Washington 98225-5996 Voice: (360) 650-3771/Confidential Fax: (360)788-0071

Employee Certification		
Employee Name (print):	on (if not employee):	
Relationship of person with medical condition (if not e	employee):	
Please answer the following questions: 1) I give permission to communicate my request for do ☐ Western Today ☐ Department Email		
2) I give permission to use my name (if no, "anonymo	us" will be used):	☐ Yes ☐ No
3) I have received donations while employed by anothout ☐ Yes ☐ No If yes, name of agency or higher	_ ·	© .
4) I am requesting leave for the following time period:	From (date)	To (date)
5) I am requesting the following type of leave: Full	l-time Reduced So	chedule Intermittent Leave
6) I am applying for shared leave due to the following	reason:	
 ☐ I have been called to military service. (Please attack) ☐ I have been accepted as a volunteer for services of the United States. (Please attack a statement of voluntary you will be assisting.) ☐ I certify I am a victim of domestic violence, sexual Violence Leave Application if not already done.) 	needed during a current feer assignment from the gor	tly declared state of emergency within pernment agency or non-profit organization the
Employee's signature:	Γ	Date:
Physician Certification – For completion by Healt		
I certify that the employee listed on this form is suffered from, an extraordinary or severe illness (serious or extraordinary or mental condition. The person's condition will remark for the following duration (which may or may not included from (date) To (date)	reme and/or life threater ain in the "serious or ex- ude the entire recovery	ening), injury, impairment, or physical streme and/or life threatening" status
Physician's Name (Print):	I	Phone #:
Physician's Signature:		
HR Approval		
Applicable leave balance is or may be depleted ☐ Yes Meets eligibility requirements ☐ Yes ☐ No ☐ If n		

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