

KANSAS STATE UNIVERSITY

SHARED LEAVE PROGRAM

Shared Leave Request Form

(10/07)

PART I - To be completed by employee.

Name _____ Employee ID # _____

Home Address _____

(City)

(State)

(Zip)

Home Telephone _____ Work Telephone _____

Department _____

Work Address _____

(City)

(State)

(Zip)

Date of employment _____

Request is for: Self _____ Family Member _____

Name of Family Member and explanation of relationship:

Date illness/injury began: _____

Anticipated duration: _____

Number of hours requested: _____

Date all paid leave will be/was exhausted: _____

Shared leave will only be granted for serious, extreme, or life-threatening illnesses, injuries, impairments or physical or mental conditions which have caused, or are likely to cause, the employee to take leave without pay or terminate employment. Shared leave will not be granted for common or minor illnesses, injuries, impairments or physical or mental conditions.

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical or mental condition is serious, extreme or life-threatening:

Are you currently receiving Workers' Compensation? _____

Are you currently receiving Long-term Disability payments? _____

Have you applied for Workers' Compensation? _____ Date Applied _____

Have you applied for Long-term Disability payments? _____ Date Applied _____

I certify that I understand, agree to, and meet the requirements and conditions of the Shared Leave program as authorized in K.A.R. 1-9-23 and KSU Policy and Procedures Manual chapter 4860 (classified employees) or 4865 (unclassified employees). I authorize the KSU Appointing Authority to obtain any necessary information, including medical documentation, regarding my request for Shared Leave. I understand that denial of this application is not subject to appeal to the Civil Service Board.

Employee Signature _____ Date _____

Department Head Acknowledgement _____

Signature

Date

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When completing forms please write legibly and be clear and thorough with explanations.

Employee Name _____ Employee ID# _____

PART II – Licensed Health Care Provider Statement.

Patients Name _____

Date first consulted for this condition _____

Describe the **nature** of the illness, injury, impairment or physical or mental condition (please attach documentation):

Describe the **diagnosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):

Describe the **treatment and prognosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):

Anticipated duration the patient will be unable to work due to the condition: From _____ Through _____

Dates of hospitalization (if applicable): From _____ Through _____

Date of Surgery (if applicable): _____

Physician Name _____ Telephone Number _____

Address _____

City State Zip

Licensed Health Care Provider Signature _____ Date _____