SUNNYSIDE SCHOOL DISTRICT
Learning Today for a Brighter Tomorrow

1110 S. 6th Street
Sunnyside, WA 98944
509-836-2274

SHARED LEAVE REQUEST FORM

Sunnyside School District employees are eligible to receive shared leave if they suffer from, or have a relative or household member as defined by RCW26.50.010, suffering from a serious or extreme and/or life threatening illness, injury, impairment, or physical or mental condition. Employees may access shared leave under the following conditions:

- ✓ The employee's job is one in which annual and/or sick leave can be used and accrued.
- ✓ The employee is not eligible for time loss compensation RCW Chapter 51.32.
- ✓ The employee has exhausted, or will exhaust his/her annual leave and/or sick leave and has abided by District policies regarding the use of sick leave.
- ✓ The condition has caused, or is likely to cause, the employee to go on leave without pay or terminate employment.
- ✓ All forms of paid leave available for use by the employee must be used prior to using shared leave.

INSTRUCTIONS: Use this form to request to receive donated shared leave for one of the reasons specified below.

RETURN: Forward this completed form to **Payroll/Human Resources** at the District Office.

TO BE COMPLETED BY REQUESTING EMPLOYEE

1. ☐ I have a "severe or extraordinary illness" or injury. If information about your condition is not currently on file in Human Resources, you will be asked to have your health care provider complete and submit a certification form.

   How long do you expect to be off work (if known) Specify Dates: From:_____ Until:_____

   Do you expect to use shared leave intermittently or on a reduced schedule: ☐ Yes ☐ No

   If you answered yes to the previous question please describe your anticipated work schedule and the length of time the schedule will need to be in place: _____

OR

2. ☐ I have to provide care for a close family or household member who has a "severe or extraordinary illness" or injury. Please identify and specify your relationship to the person for whom you are providing care:

   Name of person you are caring for:_____

   Relationship to the person you are caring for: ☐ Parent ☐ Child ☐ Spouse ☐ Domestic Partner ☐ Sibling ☐ Grandparent ☐ Household Member ☐ Parent-in-law ☐ Other-Please specify_____

   How long do you expect to be off work (if known) specify Dates: From:_____ Until:_____

   Do you expect to use shared leave intermittently or on a reduced schedule: ☐ Yes ☐ No

   If you answered yes to the previous question please describe your anticipated work schedule and the length of time the schedule will need to be in place: _____

Please confirm the following by checking the box next to the statement below. If the statement is not accurate for you, it means that you are not currently eligible to receive shared leave donations.

☐ As a result of the reason I have specified above, I will have to take leave without pay or terminate employment because I do not have sufficient paid leave to cover my absence from work.

Last Name:	First Name:	Middle Initial:

Signature:_____ Date:_____ Phone Number:_____

HR DIRECTOR REVIEW

This request for shared leave was reviewed on _____. The employee's request for shared leave is:

☐ Approved ☐ Disapproved (for the following reasons):_____

_____

Signature:_____ Date:_____

The employee was notified on _____ of the HR Director's decision via US Mail, Phone Call, or Email.

PAYROLL USE ONLY

Current Employee Leave Balances: Vacation Leave_____; Sick Leave_____; Personal Leave_____

Date Employee will go on LWOP Status:_____

I have reviewed the employee's request to receive shared leave, and the leave balances are current as of today's date:

Signature:_____ Date:_____

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HEALTH CARE PROVIDER STATEMENT

Shared Leave Eligibility Verification

TO BE COMPLETED BY REQUESTING EMPLOYEE			
Last Name:	First Name:	Middle Initial:	Employee's Job Title:
Phone Number:	Work Email:		Work Schedule (days/hours):

Is this condition the result of an on the job injury? ☐ Yes ☐ No

Are you requesting shared leave to care for a family or household member? ☐ Yes ☐ No If yes, please provide:

Family/Household Member's Name:_____Family/Household Member's Relationship:_____

I hereby authorize the above-named health care provider to complete this form and disclose to Sunnyside School District and its authorized representatives the diagnosis, treatment and anticipated duration of relevant conditions.

I understand that it may be necessary for Sunnyside School District representatives to share this information for the purposes of leave administration and approval of my request to receive shared leave. I authorize Sunnyside School District to share this information among appropriate staff and authorized representatives to the extent necessary for that purpose. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services, and treatment of alcohol and drug use.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information; b) to receive a copy of this signed authorization; and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained appropriately. This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

By signing this page, I acknowledge that I have read and agree to the terms described above.

_____ _____

Signature Date

HEALTH CARE PROVIDER – COMPLETE THIS SECTION

Your patient is asking you to disclose information about him/her so that Sunnyside School District can process a request to receive leave donations from other employees. **Please complete this form and return it via US Mail, or hand delivered to the office indicated on the bottom of this form.**

Per the Washington State Leave Sharing Program **(see RCW 41.04.665), to be eligible for shared leave based on his/her condition**, your patient must suffer from an extraordinary or severe illness, injury, impairment, or physical or mental condition, which causes or is likely to case the employee to go on leave without pay status or terminate employment. Examples might include: cancer, major surgery, chemotherapy, broken back, organ transplant, AIDS, fetal endangerment, etc.

Does the individual named above suffer from an extraordinary or severe (as defined above) condition? ☐ Yes ☐ No

EVALUATION SUMMARY

Pertinent Diagnosis(es) (Name and description of condition)	Date condition commenced or diagnosed (mm/dd/yyyy)	How long condition expected to last until (mm/dd/yyyy)	Please describe how this diagnosis meets the definition of a severe, extreme or life threatening illness or injury

Is the condition the result of an on-the-job illness or injury? ☐ Yes ☐ No

HEALTH CARE PROVIDER INFORMATION

Health Care Provider Name (please print or type)	Provider's Phone Number		
Health Care Provider's Address (Street)	City	State	Zip

_____ _____

Health Care Provider's Signature Date

Return the completed form to: Sunnyside School District, Attn: Human Resources, 1110 S. 6th Street, Sunnyside, WA 98944