WILLAMETTE UNIVERSITY

Shared Leave Request Form

Name _____

Department _____ Work Phone _____

Name of Person Disabled, if not the Employee: _____

Relationship to the Employee: _____

Provide a brief description of the nature, severity and anticipated duration of your personal or family medical hardship

_____

_____

_____

_____

To be eligible, the employee or an immediate family member must be suffering from a catastrophic and disabling illness or injury which necessitates the employee's prolonged absence from work and for which the employee has no availability of paid leave.

I certify that I meet all of the requirements as stated above, and I have read and understand the rules listed on the back of this form. I have attached a certificate from a physician or licensed health care provider which describes the illness and the injury and duration of leave needed.

I understand that if this request for Shared Leave is approved, payments are subject to all applicable taxes and will be processed through the regular payroll process.

_____ _____

Employee or Employee's Representative Date

HUMAN RESOURCES/PAYROLL USE ONLY:

I have reviewed the request in consultation with the employee's supervisor and VP/Dean and, to the best of my knowledge, this employee has met the eligibility requirements to receive contributions under the

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