STATE OF KANSAS
SHARED LEAVE PROGRAM
Shared Leave Request Form

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

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Employee ID#</th>
</tr>
</thead>
</table>

**PART I – To be completed by employee or employee’s representative**

<table>
<thead>
<tr>
<th>Name</th>
<th>Employee ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>SSN</td>
</tr>
<tr>
<td>(City)</td>
<td>(State) (Zip)</td>
</tr>
<tr>
<td>Home Telephone</td>
<td>Work Telephone</td>
</tr>
<tr>
<td>Agency Name</td>
<td>Department ID#</td>
</tr>
<tr>
<td>Date of Employment</td>
<td></td>
</tr>
<tr>
<td>Request is for:              Self</td>
<td>Family Member</td>
</tr>
<tr>
<td>Name of Family Member and explanation of relationship (please include age if child):</td>
<td></td>
</tr>
<tr>
<td>Date illness/injury began:</td>
<td>Anticipated duration:</td>
</tr>
<tr>
<td>Estimate of number of hours requested:</td>
<td>Date all paid leave will be/was exhausted:</td>
</tr>
</tbody>
</table>

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. To be eligible for consideration, an employee must not have a history of leave abuse within the last year.

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

<table>
<thead>
<tr>
<th>Are you currently receiving Worker’s Compensation?</th>
<th></th>
<th>Are you currently receiving Long-Term Disability Payments?</th>
<th></th>
<th>Date Applied:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you applied for Worker’s Compensation?</td>
<td></td>
<td>Have you applied for Long-Term Disability Payments?</td>
<td></td>
<td>Date Applied:</td>
</tr>
</tbody>
</table>

I certify that I understand, agree to and meet the requirement and conditions of the shared leave program as authorized in K.A.R. 1-9-23. I authorize the appointing authority to obtain any necessary information regarding my request for shared leave and to share that information with the Shared Leave Committee. I understand that denial of this application is not subject to appeal to the Civil Service Board. **I declare under penalty of perjury that the foregoing is true and correct.**

Executed on date below.

Employee Signature_________________________ Date ___________________
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Employee Name ___________________________ Employee ID# ______________________

PART II – Licensed Health Care provider Statement.

Patient’s 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):
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

If this request is for the care of a family member, please indicate the role they will have in the care.
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

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 ___________________
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Employee Name __________________________  Employee ID# ______________________

PART III – To be completed by the Agency human Resource Office of Umbrella Agencies.

_______ The employee has used, or will use all forms of paid leave including vacation leave, sick leave and compensatory time credits as of _________________.
_______ The employee’s last day physically at work was ____________________
_______ The employee has six months of continuous service.
_______ The Relationship meets the requirements set forth in K.A.R. 1-9-23 if the request is for the care of a family member. (Mark N/A if the request is for the employee.)

We certify that the employee meets all the initial eligibility requirements above and has maintained a satisfactory attendance and/or leave record within the past year.

Appointing Authority or Designee __________________________  Date ______________________

If an employee does not meet all the initial eligibility requirements or has not maintained a satisfactory attendance record, take no further action. File this request and notify the employee.

Please forward completed form to __ATTN: Shared Leave Committee – c/o Jolene Flowers__ Office of Personnel Services, 900 SW Jackson, Room 401-N, Topeka, KS  66612 or fax to (785) 296-7712.

Please submit the name of person to be contacted with the committee decision. This will be done by e-mail which will also be your official confirmation for records.

E-mail reply to: __________________________

PART IV – To be completed by Shared Leave Committee.

We have reviewed the request and make the following recommendation:

_______ Approve
_______ Deny – Does not rise to the level of being serious, extreme or life-threatening
_______ Return for additional information/clarification What: __________________________

Shared Leave Committee Representative __________________________  Date _______________

PART V – To be completed by the appointing authority

I hereby acknowledge the use of shared leave for _______ hours through ____________________

Appointing Authority Signature __________________________  Date _______________