STATE OF KANSAS
SHARED LEAVE PROGRAM
Shared Leave Request Form

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

Employee Name _____ Employee ID# _____

PART I – To be completed by employee or employee's representative

Name _____ Employee ID # _____

Home Address _____ SSN _____

_____

(City) (State) (Zip)

Home Telephone _____ Work Telephone _____

Agency Name _____ Department ID# _____

Date of Employment _____

Request is for: Self _____ Family Member _____

Name of Family Member and explanation of relationship (please include age if child):

_____

Date illness/injury began: _____ Anticipated duration: _____

Estimate of 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. 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:

_____

_____

_____

Are you currently receiving Worker's Compensation? _____
Are you currently receiving Long-Term Disability Payments? _____
Have you applied for Worker's Compensation? _____ Date Applied: _____
Have you applied for Long-Term Disability Payments? _____ Date Applied: _____

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 _____

DA 325 (Revised 10/14) **COMMITTEE**

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PART II – Licensed Health Care provider Statement.
IF THIS REQUEST IS FOR THE CARE OF A FAMILY MEMBER PLEASE INDICATE THE ROLE THEY WILL HAVE IN THE CARE.

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):

_____

_____

_____

_____

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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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 (please circle one) **APPROVE** **DENY** the use of shared leave for _____hours through _____

Appointing Authority Signature_____ Date_____