

# University of North Carolina at Pembroke

## Voluntary Shared Leave Program Application Form

**Section 1: To be completed by Employee. Please print or type. Incomplete forms will not be accepted. Please deliver/mail completed form to the Office of Human Resources, Lumbee Hall suite 347 or fax to 910-521-6553.**

Employee's Name: \_\_\_\_\_ Banner ID: \_\_\_\_\_

Department: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Supervisor Phone #: \_\_\_\_\_

1. I, \_\_\_\_\_ request participation in the Shared Leave Program and herewith apply for a donation of shared Leave.
2. I, or my family member \_\_\_\_\_  Spouse  Parent  Child have a medical condition that is serious and prolonged as defined in the Voluntary Shared Leave Policy and as confirmed by the physician's certification specifying the medical condition and its expected duration. I understand the physician's certification must be submitted to the Office of Human Resources before this application will be considered.
3. I understand that I may not force or coerce any individual into donating leave. The donation of leave under this program must be entirely voluntary. If the use of force or coercion is discovered, it will be viewed as unacceptable personal conduct. The employee and supervisor will be notified, and discipline may be issued.
4. I understand that I am applying to receive leave transferred from another employee's account and that my name may be known to process my request. I would like my Voluntary Shared Leave participation posted/shared with campus.  YES  NO

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Immediate Supervisor's Approval Signature

\_\_\_\_\_  
Date

**Section 2: To be completed by Office of Human Resources Authorized Official ONLY:**

Approved  Denied, Reason for Denial: \_\_\_\_\_

\_\_\_\_\_  
Office of Human Resources Authorized Official's Signature

\_\_\_\_\_  
Date

Last Day Worked: \_\_\_\_\_ LOA Date: \_\_\_\_\_ Leave Exhaustion Date: \_\_\_\_\_

Donation Period: From \_\_\_\_\_ To \_\_\_\_\_ FML designated:  Yes  No; Applied for STD:  Yes  No

Balance as of: \_\_\_\_\_ VL: \_\_\_\_\_ SL: \_\_\_\_\_ BV: \_\_\_\_\_ Comp: \_\_\_\_\_

Leave Received: \_\_\_\_\_ Leave Used: \_\_\_\_\_ Leave Returned: \_\_\_\_\_