



# Pierce County

## SHARED LEAVE REQUEST FORM

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Employee ID Number |
| Department/Position                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Contact Number     |
| <input type="checkbox"/> <b>Block of Leave</b> <input type="checkbox"/> <b>Intermittent Leave</b><br>Leave Begin Date: _____ Duration of Leave: _____<br><input type="checkbox"/> <b>Self</b> <input type="checkbox"/> <b>Family Member</b> (specify relationship): _____                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    |
| <b>Type of request – please mark all that apply:</b><br><input type="checkbox"/> Injury    Date of Injury: _____ <input type="checkbox"/> Work Related<br><input type="checkbox"/> Illness <input type="checkbox"/> Treatment<br><input type="checkbox"/> Surgery - Date: _____<br><input type="checkbox"/> Other (briefly describe; please do not provide diagnosis information): _____<br>_____                                                                                                                                                                                                                                                                                                                |                    |
| <p><b><u>IMPORTANT NOTES:</u></b><br/>         A statement from your physician or medical provider attesting to the nature of the medical condition, illness, injury or impairment; including prognosis for recovery and estimated length of absence <b>MUST</b> be provided <u>directly</u> to the Human Resources Department as per policy <u>Section 3.70.070</u>, Item A.</p> <p>If you are eligible for and collect Worker’s Compensation benefits, you are <u>not</u> eligible for this program.</p> <p>Please be advised that shared sick leave donations do <u>not</u> qualify as reportable compensation towards service credit for retirement. This is in accordance with WAC 415-108-468 (3) (b).</p> |                    |
| I acknowledge that it is my responsibility to review and become familiar with and abide by the Shared Sick Leave policy. My signature below authorizes the Human Resources Department to publish my name along with the request for sick leave donations.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    |
| <b>Signature</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Date</b>        |

### Department Director

|                                                |                          |
|------------------------------------------------|--------------------------|
| APPROVED<br>DISAPPROVED<br>UNABLE TO DETERMINE | If disapproved, explain: |
| Signature                                      | Date                     |

### Human Resources Director

|                         |                          |
|-------------------------|--------------------------|
| APPROVED<br>DISAPPROVED | If disapproved, explain: |
| Signature               | Date                     |