



# Request To Receive Shared Leave

Approval of a request for donated leave is dependent on shared leave availability and takes into consideration the best interest of the county. The Shared Leave Committee reserves the right to review the application and leave status at anytime during the absence of the employee.

By signing this form, I anticipate being absent from work for an extended period of time (at least six weeks) due to a non-job related illness or injury which is medically catastrophic (e.g. the illness/injury is extremely serious, totally incapacitating, or life-threatening) and will force me to exhaust all paid leave during this period of time. I am authorizing Forsyth County Government to make this need known to other employees.

EMPLOYEE INFORMATION			
Employee Name (First, Last, Middle Initial)			
Home Address	City	State	Zip
Employee ID #	Telephone Number <input type="checkbox"/> HOME <input type="checkbox"/> CELL		
USE OF MEDICAL INFORMATION			
I give permission for the general nature of my medical condition as described below to be released for the sole purpose of receiving donations. I can elect not to have my medical information shared by marking "no." <input type="checkbox"/> YES <input type="checkbox"/> NO			
If YES, briefly describe nature of the medical condition:			
Requested Start Date:	Anticipated Return Date:	Number of Hours Requested:	
LEAVE BALANCE			
Type	Number of Hours	Balance as of Pay Period End Date _____	
Vacation	_____		
Sick	_____		
NOTE			
<i>In the event that an employee in need of leave is incapable of completing this form, the Department Head may request Human Resources to start the process. I understand that administrative decisions will be made by the Shared Leave Committee with no right to appeal. <b>I also understand it is my responsibility to notify Human Resources 48 hours prior to my return to work date.</b></i>			
<b>A Certification of Health Care Provider form must be completed and attached before the application will be considered.</b>			
Employee Signature:		Date:	

DECISION		
Committee Chair Signature:	<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED	APPROVED # OF HOURS _____