

University of Kansas  
 Shared Leave Program  
 Shared Leave Request form

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

Name: \_\_\_\_\_ KU ID #: \_\_\_\_\_

Home Address: \_\_\_\_\_ Email: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Department Name: \_\_\_\_\_

Date of Employment: \_\_\_\_\_ Request is for (check one): Self \_\_\_\_\_ Family Member \_\_\_\_\_

Name of Family member (if applicable) and explanation of relationship:  
 \_\_\_\_\_  
 \_\_\_\_\_

Date illness/injury began: \_\_\_\_\_ Anticipated duration: \_\_\_\_\_

Estimate number of hours requested: \_\_\_\_\_ Date all paid leave will be/was exhausted: \_\_\_\_\_

**Shared leave will only be granted for 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. Shared Leave will not be granted if you have documented attendance problems, unsatisfactory work performance or a disciplinary action in the last 12 months.**

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical or mental condition is extreme 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 requirements 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. I understand that denial of this application is not subject to appeal.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Requests received by HR **before 5PM Thursday** will be reviewed by the Shared Leave Committee (SLC) and a determination will be made by 5PM Friday the following week. Requests received by HR **after 5PM Thursday** will be reviewed by the SLC and a determination will be made by 5PM in two weeks.*

## Shared Leave Request Form

Employee Name: \_\_\_\_\_ Employee ID#: \_\_\_\_\_

### **PART II – To be completed by a Health Care Provider**

Your patient has applied for Shared Leave. Please be aware that this is a separate process from the determination of FMLA. A higher standard is in place to determine if employee's health conditions meet the requirements for Shared Leave. Shared leave will only be granted for 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. **Please complete the section below in its entirety. Failure to provide requested information may result in denial or delay of shared leave. If this request is for the care of an employee's family member, please indicate the role the employee will have in the care.**

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Patient's Name: \_\_\_\_\_

Date first consulted for this condition: \_\_\_\_\_

Describe the **nature** of the illness, injury, impairment or physical or mental condition to include the **medical necessity for absence** from work (please attach documentation):

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Describe the **diagnosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):

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Describe the **treatment and prognosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):

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If *continuous* leave is necessary, anticipated duration of the medical necessity for absence from work:

From: \_\_\_\_\_ Through\*: \_\_\_\_\_ *\*If unknown, enter the date of next assessment/appointment.*

If *intermittent* leave is necessary, anticipated frequency and duration of absences from work:

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

Dates of hospitalization (if applicable): From: \_\_\_\_\_ Through: \_\_\_\_\_

Date of surgery (if applicable): \_\_\_\_\_

Health Care Provider Name (printed): \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Department of Human Resource Management**

1246 West Campus Road | Lawrence, KS 66045 | 785-864-4946 | Fax 785-864-5790 | [humanresources.ku.edu](http://humanresources.ku.edu)

**Shared Leave Request Form**

Employee Name: \_\_\_\_\_ Employee ID#: \_\_\_\_\_

**PART III – To be completed by KU Human Resources**

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\_\_\_\_\_ The employee has used, or will use all forms of paid leave including vacation leave, sick leave and compensatory credits as of: \_\_\_\_\_

\_\_\_\_\_ The employee’s last day physically at work was: \_\_\_\_\_

\_\_\_\_\_ The employee has six (6) 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).

\_\_\_\_\_ The employee has satisfactory performance.

\_\_\_\_\_ The employee has satisfactory attendance.

\_\_\_\_\_ The employee is not receiving Workers Compensation.

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\_\_\_\_\_ The employee meets all the initial eligibility requirements above, forward this request to the Appointing Authority or Designee.

\_\_\_\_\_ The employee does not meet all the initial eligibility requirements, take no further action. File the request and notify the employee.

Appointing Authority or Designee \_\_\_\_\_ Date \_\_\_\_\_

**PART IV – To be completed by Shared Leave Committee**

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We have reviewed the request and make the following recommendation:

\_\_\_\_\_ **Approve**

\_\_\_\_\_ **Disapprove.** Specific reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **Return for additional information/clarification.** Specific reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Shared Leave Committee Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**PART V – To be completed by the appointing authority**

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I hereby (please circle one)    APPROVE    DENY    the use of shared leave through: \_\_\_\_\_

Appointing Authority Signature: \_\_\_\_\_ Date: \_\_\_\_\_