THE UNIVERSITY OF KANSAS
Human Resource Management

University of Kansas
Shared Leave Program
Shared Leave Parental Leave Request form

PART I – To be completed by employee

Name: ____ KU ID #: _________________________

Home Address: _________________________________ Email: ___________________________

____
(City) (State) (Zip)

Home Telephone: ______________________________ Work Telephone: __________________

Department Name: ____

Reason for Request (check one): ____birth ____adoption ____foster care

Due Date/placement date of child: ________________________

Requested leave start date: ___________________ Requested leave end date:________________

If any of your leave will be part time or intermittent, please provide details of that plan and **include a statement of support for your part time leave from your supervisor with your application.**

Part time leave plan:____

____

____

Estimate number of hours requested: ______ Date all paid leave will be/was exhausted: __________

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

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 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. I affirm that I am either the child's natural, adoptive, or foster parent

Employee Signature:________________________________ Date:_________________________

Employee Name:___________________________________ Employee ID#:_____________________

PART II – One of the following two sections must be completed

To be completed by a Health Care Provider for the birth of a child
Your patient has applied for Shared Leave. Please be aware that this is a separate process from the determination of FMLA. **Please complete the section below in its entirety. Failure to provide requested information may result in denial or delay of shared leave.**

Parent('s) Name(s):____

Is the above listed employee expecting a child: ___yes ___no

Expected delivery date of the child: __________________

Health Care Provider Name (printed):____

Telephone Number:________________________Fax:_____________________________________

Address: ____

____

(City) (State) (Zip)

Health Care Provider Signature:________________________________ Date:________________

OR

To be completed by an adoption or foster agency for the placement of a child through adoption or foster care
Your client has applied for Shared Leave. Please be aware that this is a separate process from the determination of FMLA. **Please complete the section below in its entirety. Failure to provide requested information may result in denial or delay of shared leave.**

Parent('s) Name(s):____

Is the above listed employee expecting a child to be placed with them: ___yes ___no

Expected placement date of the child: __________________

Placement has occurred through ___adoption ___foster care

If placement is through foster care please provide the end date of the placement (if applicable): ____________

Adoption/Foster Agency Representative Name:____

Adoption/Foster Agency Name: ____

Telephone Number:________________________________Fax:______________________________

Address: ____

____

(City) (State) (Zip)

Adoption/Foster Agency Representative Signature:_____________________________________ Date:________________

Shared Leave Request Form

Employee Name:_______________________________________ Employee ID#:__________________________

PART III – To be completed by KU Human Resources

______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 <u>not</u> receiving Workers Compensation.

______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 V – To be completed by the appointing authority

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

Appointing Authority Signature:____Date:_____________________