KU THE UNIVERSITY OF KANSAS
Human Resource Management

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.**

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):

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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.*

Provide supporting information why it is medically necessary to be off of work on a continuous basis and unable to perform work in any capacity i.e. full-time treatment/appointments/physical limitations:

_____

_____

_____

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:_____

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 not 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 IV – To be completed by Shared Leave Committee

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

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

Appointing Authority Signature:_____Date:_____