OHR 325 (Revised 07-09) **COMMITTEE**

STATE OF KANSAS
SHARED LEAVE PROGRAM
Wichita State University
Shared Leave Request Form

When completing form please write legibly and be clear and thorough with explanations. A Certification of Health Care Provider form must also be completed for each new request or request to extend shared leave.

PART I – To be completed by employee or employee's representative

Name: ______________________________ Employee *myWSU id* #: ______________
Home Address: ____

______________________ ____________ ____________
(City) (State) (Zip)

Home Telephone: ____________________ Work Telephone ______________
Department Name: ____
Supervisor's Name: ______________________________ Extension ____________
Date of Employment: ______________
Request is for: Self __________ Family Member __________
Name of Family Member and explanation of relationship (please include age if child):

____

Date illness/injury began: ______________ Anticipated duration: ______________
Estimate of number of hours requested: __________ Date all paid leave will be/was exhausted: ____________
Last day of work: ______________

Shared leave will only be granted for serious, 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. To be eligible for consideration, an employee must not have a history of leave abuse within the last year.

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical condition is serious, extreme or life-threatening:

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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: ____________

(An employee receiving Workers' Compensation or Long-Term Disability is ineligible for Shared Leave.)

I certify that I understand, agree to and meet the requirement 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 and to share that information with the Shared Leave Committee. I understand that denial of this application is not subject to appeal to the Civil Service Board. **I declare under penalty of perjury that the foregoing is true and correct.** Executed on date below.

Employee's Signature: ______________________________ Date: ____________

FORWARD COMPLETED FORM TO Lana Anthis, Wichita State University, Office of Human Resources, Campus Box #15, Wichita KS 67260-0015 or Fax to: (316) 978-3201.