OHR 325 (Revised 6-18) **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 Healthcare Provider Form must also be completed for each new request or request to extend shared leave.

To be completed by employee or employee's representative

Name:_____ Employee *myWSU ID #*:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

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 number of hours requested:_____ Date all leave will be 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. If you are receiving workers compensation, long-term disability payments, or both, you are not eligible to receive shared leave per WSU policy. Shared leave will not be granted for common or minor illnesses, injuries, impairments or physical or mental conditions.

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

_____

_____

_____

Is this a work-related injury? _____

Are you currently receiving Worker's Compensation?_____

Are you currently receiving Long-Term Disability?_____

Have you applied for Worker's Compensation?_____ Date applied:_____

Have you applied for Long-Term Disability?_____ Date applied:_____

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

I certify that I understand, agree to and meet the requirements and conditions of the shared leave program as authorized in WSU policy. 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. **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: Leave Administrator, Human Resources, Wichita State University, 1845 Fairmount St, Campus Box 15, Wichita KS 67260-0015 or Fax to 316-978-3201 or email to totalrewards@wichita.edu