EMPLOYEE NAME (PRINT)	EMPDYEE CWID#	DEPARTMENT
EMAIL	PHONE #	
I am requesting hours of Shared Program Policy.	Sick Leave under the terms	s speci ed in the Shared Sick Lea
hereby acknowledge and certify the following	ng:	
 I have enclosed a completed physician immediate family member. 	n's certi cation of a serious	health condition for myself or an
 I agree that I will notify the O ce of Huma income protection bene ts (such as SSI, donated sick leave. 		
 I acknowledge that I have read and und Leave Program Policy. 	derstand the program provis	ion as set forth in the Shared Sich
 I understand that documentation of havi on behalf of the employee recipient. 	ng a Power of Attorney is red	quired with this form if I am acting
DATE MEDICAL CONDITION BEGAN	DATE MEDICAL CO	ONDITION IS EXPECTED TO END
SIGNATURE OF RECIPIENT OR AUTHORIZED REF	PRESENTATIVE DATE	

SB421

Γ'	OK USE BY THE	OFFICE OF HUN	MAN RESOURCES	
Type of Request: Initial Status of Request: App	·	•		
Your request for donated			lowing reasons:	
Tour request for dollated	i leave calliot be acc	septed due to the foll	iowing reasons.	
SHARED SICK LEAVE PROG	GRAM ADMINISTRATOR	SIGNATURE DATE		

You may appeal the denial of this decision by submitting this notice along with a written statement to the O ce of Human Resources Shared Sick Leave Program Administrator.