**SHARED LEAVE REQUEST**

**Employee name**  
**Personnel ID number**  
**Facility/office**

**Dates of requested leave:**  
**Begin:** __________  
**End:** __________

Estimate begin date when leave balances will be ZERO. Maximum 90 days for medical condition/event, 60 days for domestic violence.

Per WAC 357-31-390, I request approval to receive shared leave. To be eligible to receive shared leave the following conditions must all apply:

- I have abided by DOC 830.100 Leave and am eligible to accrue sick or vacation leave
- This condition/situation is likely to cause me, or has caused me, to take leave without pay or terminate my employment
- I have attached documentation verifying my condition/situation as required per DOC 830.030 Shared Leave
- I have diligently pursued and been found ineligible for workers’ compensation benefits from the Washington State Department of Labor and Industries. If approved at a later time, all leave received may be returned to the donors.

If I am approved to receive shared leave, I approve the following e-mail message to be sent and/or posted on my behalf soliciting leave donations: “*(Name) of (Facility/Office) has been approved to receive shared leave. Employees interested in donating leave should submit DOC 03-115 Shared Leave Donation to their Payroll Office.*”  

☐ Approved  ☐ Waived

**Signature**  
**Date**

**SUPERVISOR APPROVAL**

☐ Recommend approval  ☐ Recommend denial

**Name**  
**Signature**  
**Date**

**HUMAN RESOURCES APPROVAL**

Leave balance as of _______________  
**Sick:** __________  
**Vacation:** __________

**Sub-agency:**

Shared leave use:  
☐ Continuous  
☐ Intermittent  
☐ Parental leave  
☐ Temporary pregnancy disability

Employee  
☐ has  
☐ has not  
complied with the requirements per WAC 357-31-390

☐ Recommend approval  ☐ Recommend denial

**Human Resource Manager/designee**  
**Signature**  
**Date**

**APPOINTING AUTHORITY APPROVAL**

☐ Recommend approval  ☐ Recommend denial

**Name**  
**Signature**  
**Date**

**SUPERVISOR REPORT**

Actual date employee returned to work: _______________

**Name**  
**Signature**  
**Date**

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

**Distribution:**  
**ORIGINAL** - Medical/domestic violence: Employee Occupational Health Record, verifying documents  
Military/volunteer: Personnel File, verifying documents  
**COPY** - Superintendent, Payroll Office