



APPLICATION FOR SHARED LEAVE

ALEXANDER COUNTY

NAME _____

DEPARTMENT _____

I have exhausted (or will exhaust) all of my compensable benefits (holidays, vacation, accumulated sick leave and comp. Time) as of _____

Due to ___ my prolonged catastrophic illness or injury; OR ___ the prolonged catastrophic illness or injury of my _____ (immediate family member).

This situation is expected to prevent me from returning to work until approximately _____. I understand that I am responsible for providing adequate medical certification from the primary attending physician. I will provide medical certification of "fitness for work" upon my return to work.

I have read and understand the guidelines of the Alexander County Shared Leave Pool policy. Further, I agree to abide by all guidelines established under the Alexander County Shared Leave Pool policy.

Signature of Requesting Employee

Date

Signature of Department Head

Date

APPROVAL

Human Resource Director's Signature

Date