APPLICATION FOR SHARED LEAVE

ALEXANDER COUNTY

EMPLOYEE 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