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  

Signature of Department Head  

**APPROVAL**  

Human Resource Director’s Signature  

Date