



# Pierce County

## SHARED LEAVE REQUEST FORM

Name		Social Security Number	
Department		Phone Number	Timekeeper Location
<b>Leave Balances</b>		Date of Balances	Is this condition a job related injury?
Sick Leave	Vacation Leave	Comp Time	Holiday

Briefly describe the condition that causes your need for shared sick leave. **NOTE: Statement from your physician attesting to the nature of the medical condition, illness, of injury; including prognosis for recovery and estimated length of absence must be submitted with your request form or forwarded directly to the Human Resources Department.**

Chapter 3.70 Shared Sick Leave 3.70.030 Definitions

B. "Catastrophic Medical Condition, Illness, Injury or Impairment" means a physician certified death eminent case or a medical condition, illness, or injury which is of an extraordinary or severe nature and which has caused, or is likely to cause, the employee to: (i) be incapacitated and unable to work in excess of five (5) working days; (ii) or otherwise be required to terminate County employment due solely to the absence of any available leave. Notwithstanding the above, Shared Sick Leave will not be approved if based on the physician's certification and consideration of the employee's condition, the employee is not expected to return to County employment.

Please be advised that if you receive compensation from a collateral source (to include but not limited to short/long term disability, social security benefits, third party subrogation claims, etc.) for the same injury/illness, covering the same period of time, you will need to notify the Human Resources Department of this information. This information will be included in the review to determine your eligibility or the amount of benefit allowed. Also, if you are eligible for and collect Worker's Compensation benefits, you are not eligible for this program.

In addition, please be advised that shared sick leave donations do not qualify as reportable compensation towards service credit for retirement. This is in accordance with WAC 415-108-468 (3) (b).

I acknowledge that it is my responsibility to review and become familiar with and abide by the Shared Sick Leave policy. My signature below authorizes the Human Resources Department to publish my name along with the request for sick leave donations.

<b>Signature</b>	<b>Date</b>
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**Department Director**

APPROVED [ ] DISAPPROVED [ ]	If disapproved, explain:
Signature	Date

**Human Resources Department Director**

APPROVED [ ] DISAPPROVED [ ]	If disapproved, explain:
Signature	Date

Original: File    Copies: Employee    Department    Payroll