CLASSIFIED LEAVE SHARING PROGRAM

APPLICATION FOR DIRECT TRANSFER OF LEAVE

To be completed by employee (please type or print legibly in ink).

Name_____ Social Security # _____

Home Address/City/Zip_____

Home Telephone_____

Department _____ Job Title _____

Date .5 or above employment began_____

Full Time _____ Part Time _____ % Time _____ Monthly Salary _____

Request is for: Self _____ Child ____ Parent _____ Spouse ____

Have you also applied for:
Worker's Compensation _____ Disability Retirement _____ Short Term Disability _____

Date illness/injury began _____ Anticipated duration _____

Date all sick and annual leave will be/was exhausted_____

Number of days Requested_____

Briefly describe the nature of illness/injury and how it meets the "Direct Threat to Life" requirement:

_____

_____

_____

_____

_____

_____

I hereby certify that I understand, agree to, and meet the requirements and conditions of the leave transfer

program in accordance with State Classified Procedures 5-12 and 5-13. Also I hereby authorize the university President or his designee to obtain any necessary information concerning this application. I understand that denial of this application is not subject to grievance or appeal. I hereby certify that, to the best of my knowledge, the above information is accurate.

Signature of Employee_____ Date_____

To be completed by Supervisor, Human Resources and President.

_____ Support _____ Not Support

Signature of Supervisor_____ Date_____

_____ Eligible _____ Not Eligible

Signature of HR Representative_____ Date_____

_____ Approved _____ Not Approved

Signature of President_____ Date_____