SAVANNAH STATE UNIVERSITY

Shared Sick Leave Program – Request Form

INSTRUCTIONS: Please complete and return this Shared Sick Leave Request form and the Physicians Certification form to the Office of Human Resources.

Employee Name: _____ Employee ID: _____

Phone # : _____ Email: _____

Department: _____ Supervisor: _____

I am requesting _____hours of Shared Leave under the terms specified in the Shared Sick Leave Program Policy.

I hereby acknowledge and certify the following:

- I am an active member of the Shared Sick Leave Program.
- I have enclosed a completed physician's certification of a serious health condition for myself or an immediate family member.
- I agree that I will notify the Office of Human Resources if I am approved for other benefits (i.e., Workers Compensation, Short or Long Term Disability, Social Security Insurance, Disability Retirement, etc.) prior to or after I begin receiving donated sick leave.
- I acknowledge that I have read and understand the program provision as set forth in the Shared Sick Leave Program policy.
- I understand that documentation of having a Power of Attorney is required with this form if I am acting on behalf of the employee recipient.

_____ _____

Date Medical Condition Began Date Medical Condition is Expected to End

_____ _____

Signature of Recipient/Authorized Representative **Date**

FOR USE BY THE OFFICE OF HUMAN RESOURCES

Type of Request: ☐ Initial Request ☐ Secondary Request

Status of Request ☐ Leave Request Approved ☐ Leave Request Not Approved

Your request for donated leave cannot be accepted due to the following reasons:

_____

_____

_____

_____ _____

Shared Sick Leave Program Administrator Signature **Date**

Note: If this request is denied and you wish to appeal this decision, submit your appeal along with this notice, in writing to the Office of Human Resources – Shared Sick Leave Program Administrator.