

Augusta University

Shared Sick Leave Program – Request Form

Employee Name (Print)

Empl ID #

Department

Email

Phone#

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 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 benefits under Social Security Insurance or disability retirement 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 or Authorized Representative

Date

INSTRUCTIONS: Please complete and return this Termination of Membership form to the Benefits Analyst in Benefits & Data Management located in HS 1126 in the Annex I building.

Augusta University

FOR USE BY THE BENEFITS & DATA MANAGEMENT OFFICE

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

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 Administer.