LEAVE SHARING REQUEST

1.

Name:		Employee ID:	
Position:		School/Department:	

Check the reason you are requesting shared leave and provide any additional information requested:

a. ☐ I have a "severe or extraordinary" illness or injury (see next page for examples). If information about your condition is not currently on file in Employee Services, you must first have your health care provider complete and submit a certification form.

b. ☐ I have to provide care for a close family or household member who has a "severe or extraordinary" illness or injury. If information about your family/household member's condition is not currently on file in Employee Services, you must first have your health care provider complete and submit a certification form.

Name of person you are caring for: _____

Relationship to the person you are caring for:

☐ Spouse ☐ Child ☐ Parent ☐ Registered Domestic Partner

☐ Other – Please specify _____

c. ☐ I have the need to take time for parental leave.

Please confirm the following by checking the box next to the statement. If the statement is not accurate for you, it means that you are not currently eligible to receive shared leave donations.

☐ I certify that I meet the qualifications for leave sharing eligibility under RCW 41.04.665. As a result of the reason I have specified above, I will have to take leave without pay or terminate employment because I do not have sufficient paid leave to cover my absence from work.

Signature _____ Phone Number _____ Date _____

2. Union Representative Recommendation: ☐ Approve ☐ Deny

Signature _____ Phone Number _____ Date _____

3. Employee Services Determination: ☐ Approved ☐ Denied

Signature _____ Date _____

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Instructions:

1. *Employee completes Section 1 and attaches health care provider certification.*
2. *Employee gives this form with certification to union representative who completes Section 2.*
3. *Union representative returns form with certification and recommendation to Employee Services for processing.*

Shared Leave Definitions

Examples of Extraordinary or Severe Illness or Injury

- cancer
- major surgery
- chemotherapy
- broken back
- fractured pelvis
- liver transplant
- heart transplant
- AIDS
- fetal endangerment
- hysterectomy

Examples of conditions that are not considered "an extraordinary or severe illness or injury"

Normal and uncomplicated:

- **Common cold**
- **Fever unrelated to other conditions**

Household Member

A person who resides in the same home and who provides reciprocal personal and financial support to the employee.

Close Family Member

A spouse, child, stepchild, grandchild, parent, or grandparent.

Shared Leave Questions and Answers

Are there laws that school districts must follow regarding leave sharing?
Yes. In Washington State, the law regarding the leave sharing program is RCW 41.04.660.

Is there a general pool for shared leave donations?
No. Each donation must be directed to a specified recipient.

May an eligible employee use shared leave for a reduced schedule or an intermittent leave of absence due to an extraordinary or severe illness or injury?
Yes, so long as the employee otherwise qualifies for shared leave.

Is there a minimum balance of sick leave hours that leave donors must maintain?
All employees, whether part-time or full-time, must maintain a minimum balance of 176 hours of sick leave after their donation.

If I donate leave will it be deducted from my attendance incentive calculation?
No. The donated hours will not be considered when calculating attendance incentives.

LEAVE SHARING REQUEST

Documentation/Certification of Health Condition

To: PASCO SCHOOL DISTRICT
EMPLOYEE SERVICES DEPARTMENT
ATTN: HR GENERALIST
1215 W LEWIS ST
PASCO WA 99301

Phone: (509) 543-6712
Fax: (509) 543-6728

From: _____ Date: _____
Name of Attending Health Care Provider

_____ _____
Patient's Name: Last, First, Middle — Position

is currently under my care for:

_____

_____

_____

_____

_____

Health condition commenced on: _____

Probable duration of condition: _____

If the condition or treatment is intermittent, indicate dates and duration of treatment.

_____

_____

_____

_____ _____
Signature of Health Care Provider — Printed Name of Health Care Provider

_____ _____
Address — Phone Number

_____
Date

Instructions to employee: *Please submit this form to your attending health care provider for completion and return to the Employee Services Department. It may also be faxed to the number above.*