Application for Shared Leave – University of Oklahoma Shared Leave Program

Return to the Shared Leave Program - ATTN: Shared Leave Coordinator, Human Resources

Part A - To be completed by the Applicant	
Name:	Telephone:
Department:	Job Title:

My absence(s) requiring shared leave will be (choose one): ☐ Continuous* ☐ Intermittent**

*Continuous Leave request refers to scheduled leave on consecutive days (ex: Monday through Friday).
**Intermittent Leave request refers to scheduling leave on non-consecutive days or times (ex: Monday and Thursday).

I need leave for the following dates and times:

Leave Type	State Date	End Date	Total Hours Requesting
Continuous			
Intermittent			

I have read and understand, or I have had an opportunity to read and understand, the Shared Leave Program policy, and I promise to comply with the policy. I understand and agree that I cannot lawfully use and will not use shared leave if any other form of payment for the period is available and that I cannot and will not accept shared leave except for such periods of time for which I would otherwise be unpaid. I understand that a completed University Shared Leave Program Certification of Attending Doctor form, job description form is required and has been sent to HR Administration.

→ Signature:	Date:

Part B - To be completed by the applicant's departmental payroll representative.		
Applicant's Employee ID Number:	University Service Date:	
Applicant's Paid Leave Balance:	Applicant's Extended Leave Balance:	Verified on: / /
Employee's job title:	Regular work schedule:	

I am the applicant's payroll representative and I certify that the applicant has at least twelve consecutive months of employment immediately preceding today's date and the applicant is a 12-month benefits-eligible employee who accrues paid leave. I understand that shared leave may only be used as a replacement for leave without pay when the applicant is unable to work because of the medical condition for which the shared leave is applied for and approved, and that shared leave is paid the same as other paid leave and is charged to the Shared Leave Committee's account. I will retain a copy of this form in the applicant's records.

→Signature:	Printed Name:	Date:

Part C - To be completed by the applicant's departmental budget unit head

I am the applicant's budget unit head, and I acknowledge that I am aware of the applicant's request by this application and certify that the applicant: **1)**Meets normal work requirements or performs beyond the normal work requirements as indicated on the current Staff Performance Evaluation Summary Report; **2)** Has had no Positive Disciplinary Actions during the last twelve months and; **3)** Is eligible for and can effectively use this leave, to the best of my knowledge and belief. Based on this and any other knowledge of which I may be aware, I recommend this application:

☐ Be Approved. ☐ Not Be Approved Because (Attach document with explanation if needed)

→Signature:	Printed Name:	Date:

For Human Resources Use

Approved _____ Yes _____No Number of hours approved: _____

HR Shared Leave Coordinator initials _____ Date _____

Certification From Attending Physician **The University of Oklahoma Shared Leave Program**

What Is This Form For? Employees experiencing a catastrophic or life threatening illness that limit their ability to work do not always have enough paid leave hours to cover their illness-related time off. These employees have the option to request a donation of paid leave from the University of Oklahoma Shared Leave Program. This is a university-sponsored and employee-managed program which OU staff can voluntarily donate leave hours to a shared leave pool. The Employee Shared Leave Committee manages the leave pool and awards leave time based on need and availability. The information requested on this form is needed to help the shared leave committee make their decision. Thank you for taking the time to provide the information requested. When completing this form please only provide the information requested related to the condition for which the employee is requesting Shared Leave. If you have any questions about the form or this process, please contact OU Human Resources (Norman: 405-325-2961, HSC: 405-271-2180, Tulsa: 918-660-3190).

Please provide information requested on this form so that I may complete my application to the Shared Leave Program.	
Patient's First Name:	Patient's Last Name:
→ Patient's Signature (or authorized representative) Authorizing Information	Date:

Please Attach The Following Information To This Form:

1. Explain in layperson's terms the medical facts describing the patient's condition. Include in a brief narrative the history of the condition, the date the condition commenced or was diagnosed, and its cause if this is not apparent from the description of the condition.

2. What is the probable duration of the condition, or the probable duration of the patient's present incapacity if different?

3. Will it be necessary for the patient to work intermittently or to work on a less than full-time schedule as a result of the condition (including for treatment described in Item 6 below)? If yes, give the probable duration.

4. If the condition is chronic, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.

5. If the patient will be absent from work on an intermittent or part-time basis because of treatment related to the condition, please estimate the probable number of treatments, the intervals between such treatments (including dates, if known), and the period required for recovery, if any. If any of these treatments will be provided by another health provider (e.g., physical therapist), please state the nature of the treatments.

6. Is the patient unable to perform work of any kind? ☐ Yes ☐ No

7. If the patient is able to perform some work, is the patient unable to perform any one or more functions of the job? The patient should supply you with information about the functions of the job. If yes, please list the job functions the patient is unable to perform.

Print Physician's Name:	Type of Practice:	
Location Address:		
→ Physician's Signature:	Date:	Contact Phone: