LOWER COLUMBIA COLLEGE
SHARED LEAVE REQUEST FORM

The purpose of the shared leave program is to permit state employees, at no significantly increased cost to the state, of providing leave to come to the aid of another state employee that meets one of the four criteria outlined below (WAC 357-31-390, Article 13 of Collective Bargaining Agreement).

**Please note that if the medical leave is planned/scheduled, employees may not receive retro shared leave donations. They will receive donations for absences occurring after the form is submitted and approved.*

Requesting Employee's Section

I request to receive shared leave through Lower Columbia College's shared leave program. I qualify for shared leave because I:

- ☐ Suffer from, or have a relative or household member suffering from an illness, injury, impairment, or physical or mental condition, which is of an extraordinary or severe nature
  - ☐ Self
  - ☐ Relative/Household Member
- ☐ Suffer from pregnancy disability
- ☐ Will be bonding with a new baby or newly placed child Have been called to service in the uniformed services
- ☐ Am a victim of domestic violence, sexual assault, or stalking as defined in RCW 41.04.655
- ☐ Have volunteered my services to either a government agency or nonprofit organization engaged in humanitarian relief after a devastating event

Is this an elective surgery?

- ☐ Yes
- ☐ No

The qualifying reason above has caused, or will likely cause me to go on leave without pay status or terminate my state employment.

I request the LCC notify employees of my need for shared leave donations.

- ☐ Yes
- ☐ No

________________________________ ______________________

Printed Name Date

____

Signature

FOR HUMAN RESOURCES USE ONLY

Approve Deny

Human Resources Date

VERIFICATION PROCESS

To consider shared leave requests, LCC requires specific information that serves as verification of the requesting employee's eligibility for shared leave. For each qualifying reason selected on the shared leave request form, additional information and/or documentation must be obtained. Based on your qualifying reason for requesting shared leave, see the additional information/documentation to provide below.

Medical Condition
Employee's medical provider or relative/household member's medical provider must complete the medical certification form. The completed form is submitted to Human Resources.

Military
Submit a copy of the military orders verifying employee's required absence to Human Resources.

Victim of Domestic Violence, Sexual Assault or Stalking
Provide one of the following to Human Resources:

a) A police report indicating that you are a victim of domestic violence, sexual assault, or stalking;
b) A court order protecting or separating you from the perpetrator of the act of domestic violence, sexual assault, or stalking;
c) Evidence from the court or prosecuting attorney that you appeared or are scheduled to appear in court in connection with the incident of domestic violence, sexual assault, or stalking;
d) Written statement that you are a victim of domestic violence, sexual assault, or stalking;
e) Documentation that you are a victim of domestic violence, sexual assault, or stalking from anyone with whom is familiar with your situation, an attorney, member of the clergy, medical or other professional

Volunteered Services for Emergency
Provide proof of acceptance of an employee's offer to volunteer for either a government agency or nonprofit organization during declared state of emergency.

MEDICAL CERTIFICATION FOR SEVERE MEDICAL CONDITION

Per the Washington State Leave Sharing Program (RCW 41.04.665), for your patient to be eligible for shared leave, they must suffer from an extraordinary or severe illness, injury, impairment, or physical or mental condition, which causes or is likely to cause the employee to go on leave without pay status or terminate employment.

"Severe" or "extraordinary" is defined as serious or extreme and/or life threatening.

A licensed physician or health care practitioner must complete the following medical certification.

Name of person with medical condition:___________________________________

1. Does the employee or the employee's relative/household member suffer from a medical condition which is serious or extreme and/or life threatening?

   Yes   No

2. Describe the medical facts that support your determination that the employee or relative/household member does/does not suffer from a condition that is serious or extreme and/or life threatening.

3. State the date the condition commenced and the probable duration of the condition.

HEALTH CARE PROVIDER INFORMATION

Printed Name of Medical Provider	Type of Practice
Location	Phone
Signature	Date