REQUEST TO RECEIVE SHARED SICK LEAVE

Please read ALL of the information below:

1. A school employee is eligible to receive donated leave if the following conditions are met:
    1. The staff member suffers from, or has a relative or household member suffering from, an extraordinary or severe illness, injury, impairment or physical or mental condition.
    2. The staff member's condition or circumstance has caused or is likely to cause the staff member to:
        1. Go on leave – without pay status; or
        2. Terminate their employment;
    3. The staff member's absence and the use of shared leave are justified by documentation;
    4. The staff member has depleted, or will shortly deplete, their annual leave and sick leave reserves;
    5. The staff member has abided by district rules regarding sick leave use; and
    6. The staff member has diligently pursued and been found to be ineligible to receive industrial insurance benefits.
2. The Head of School or designee will determine the amount of leave, if any, which a staff member may receive under this policy and procedure. However, a staff member shall not receive more leave than the number of contracted days remaining within their contract for the current school year.
3. Leave will be calculated on a day-donated and day-received basis
4. The school will require the employee or their legal representative to submit, prior to approval or disapproval, documentation from a licensed physician or other authorized health care practitioner verifying the severe or extraordinary nature, and expected duration of the condition. (WAC 392-126-095)
5. Request to see Policy 5406P: Leave Sharing for additional details

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REQUEST TO RECEIVE SHARED SICK LEAVE

If you would like to receive shared sick leave, ***please read the attached document before completing this form.*** *Once completed, submit to the Payroll/HR Department.*

EMPLOYEE REQUESTING SHARED LEAVE

Name _____ Date _____ Phone _____

Location _____ Position _____ Hrs/Day ___

I wish to apply for shared leave for the following situation(s) described below:

_____

_____

_____

_____

HIPPA RELEASE STATEMENT *(Select one of the following):*

__ I **WANT** Spokane International Academy to state my medical condition in my request to receive shared sick leave

__ I **DO NOT WANT** Spokane International Academy to state my medical condition in my request to receive shared sick leave

Signature _____ **Date** _____

PAYROLL/HR DEPARTMENT USE ONLY

Sick Leave Hours Balance of _____ as of _____

Short-term Disability Available? **YES ___ / NO ___**

Projected to use all available leave by _____

Is the employee receiving Worker's Compensation? **YES ___ / NO ___**

Did the employee provide official documentation as proof of condition? **YES ___ / NO ___**

Name/Title _____

Signature _____ **Date** _____

SCHOOL DETERMINATION

APPROVED ___ / DENIED ___

Name/Title _____

Signature _____ **Date** _____