Application to Receive Shared Leave

Submit to benefits@everettsd.org

I, _____, am making application to receive _____days
Print Name and Employee ID Number
of shared leave under Everett Public Schools' shared leave program for dates beginning _____
through _____.

To care for relative or household member, if applicable: _____

I understand that in order to participate in the shared leave program governed by the conditions outlined in WAC 392-136A:

1. I must be on an approved Leave of Absence authorized by through the Payroll and Benefits office, and
2. I am (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, that prevents me from working; I have been called to service in the uniformed services; I am a current member of the uniformed services or veteran and need to attend medical appointments for a service connected injury or disability; I am a victim of domestic violence, sexual assault or stalking; I am sick or temporarily disabled because of pregnancy disability OR I need the time for parental leave; and
3. I have abided by the district's sick leave or military leave policies and have depleted or will shortly deplete my annual leave (vacation) and/or sick leave reserves*; and
4. I have not received more than 522 days of shared leave during my total employment by the state of Washington or any state agencies, including employment by other school districts within the state; and
5. My condition may soon cause me to go on leave without pay or to terminate district employment; and
6. I have provided the shared leave medical documentation form signed by a licensed physician or authorized health care practitioner verifying the extraordinary or severe health condition that prevents me (or a relative or household member) from working and expected duration of the condition, or a pregnancy-related medical condition or miscarriage. This documentation is not required for parental, domestic violence or uniformed service leave.

***** You have the option to maintain no more than 40 hours of a paid leave balance under the following conditions detailed in item #2 above:

Up to 40 hours of SICK leave	Self- or family-illness, injury; military service-connected injury for self or spouse; pregnancy-related condition; parental leave
Up to 40 hours of VACATION leave	Self- military service; military service-connected injury for self or spouse; domestic violence/assault; pregnancy-related condition; parental leave

I wish to maintain _____ (*no more than 40*) hours of _____ (*sick and/or vacation*).

I also understand that all donations must be given voluntarily and that I will not coerce, threaten, intimidate, or financially induce my co-workers into donating sick or annual (vacation) leave. **As donations are voluntary, they are not guaranteed.**

My signature below indicates I have read attest to the validity and agreement of the conditions listed above:

_____ _____
Employee's Signature Date

Section Below to be Completed by Payroll and Benefits Administrator

☐ **APPROVED** ☐ **DENIED**

_____ _____
Payroll and Benefits Authorization Date

Notes:

Revised: 3/31/2023