Human Resources
1980 Arthur Street
Louisville, KY 40208-2770

Attn: Cammie Bordenkircher
Phone: 502.852.0682
Fax: 502.852.5665

Please Return This Completed Application
With Certification of Health Care Provider

Staff Request for Shared Leave Program

THIS FORM WILL NOT BE PROCESSED WITHOUT THE CERTIFICATION OF HEALTH CARE PROVIDER FORM.

*Please type or print legibly **in** ink.*

Employee Name: _____
First Middle Last

Home Address: _____

_____
City State Zip

Telephone: ( ) _____ ( ) _____
Home Other

Employee identification number: _____

Department you are employed in: _____

Supervisor's Signature:_____ Supv. Employee id _____

Job Title: _____

Please note: *This form may be completed by a personal representative, including supervisor, to request leave on employee's behalf if the employee is incapacitated.*

PART A: MEDICAL FACTS:

1. Is your injury/illness work related? ____Yes ____No
2. Please provide a brief summary of why accrued leave is not available and shared leave hours are needed.

   _____
   _____

   Maximum donation that may be received per FML period: 480 (40 hr. work week), 450 (37.5 hr. work week) 360 (30 hr. work week)

Certification

I certify that the information in my application is accurate. Further, I understand that denial of this application is not subject to the grievance or appeal procedures.

_____ _____
Employee Signature **Date**