



*North Carolina Department of Health and Human Services  
Voluntary Shared Leave*

**Voluntary Shared Leave Application**

Name of Recipient \_\_\_\_\_

BEACON Personnel Number \_\_\_\_\_

Division/Section \_\_\_\_\_ Position Title \_\_\_\_\_

Leave requested for Employee \_\_\_\_ Immediate Family \_\_\_\_ Relationship to Employee \_\_\_\_\_

GENERAL MEDICAL CONDITION (PHYSICIAN STATEMENT ATTACHED) \_\_\_\_\_

APPROXIMATE PERIOD OF PARTICIPATION IN THIS PROGRAM \_\_\_\_\_

VACATION LEAVE BALANCE \_\_\_\_\_ SICK LEAVE BALANCE \_\_\_\_\_

BONUS LEAVE BALANCE \_\_\_\_\_

**EMPLOYEE'S AUTHORIZATION**

I, \_\_\_\_\_, HAVE REQUESTED, OR HAVE BEEN NOMINATED, TO RECEIVE LEAVE UNDER THE PROVISIONS OF THE VOLUNTARY SHARED LEAVE POLICY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND HEREBY AUTHORIZE THE AGENCY TO DISCLOSE MY NEED FOR DONATED LEAVE.

RECIPIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I request the following specific State Agencies be contacted for leave donations: \_\_\_\_\_

I request the following employee(s) be contacted NAME(S): \_\_\_\_\_

\_\_\_\_\_ at DEPT/AGENCY \_\_\_\_\_

HR CONTACT: \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**For Human Resources Staff Use Only**

AMOUNT OF LEAVE RECEIVED: VACATION \_\_\_\_\_ SICK \_\_\_\_\_ BONUS \_\_\_\_\_

AMOUNT OF LEAVE RETURNED: VACATION \_\_\_\_\_ SICK \_\_\_\_\_ BONUS \_\_\_\_\_

APPROVED \_\_\_\_ NOT APPROVED \_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ACCOUNT CLOSED \_\_\_\_\_