STATE OF MISSOURI
DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

LEAVE SHARE APPLICATION

CONFIDENTIAL

		DATE	
EMPLOYEE NAME	DIVISION	SOCIAL SECURITY NUMBER	
HOME ADDRESS	CITY	STATE	ZIP CODE

REQUEST FOR LEAVE SHARE

REASON FOR REQUEST

(Include information about the nature of your illness or injury and anticipated time off work. Attach a Leave Share Physician's Statement including a diagnosis and prognosis.)

TOTAL SHARE HOURS REQUESTED BY APPLICANT _____

I authorize any hospital, physician or any other provider of service to release information which the department needs to determine benefits applicable with this request.

EMPLOYEE/REPRESENTATIVE'S SIGNATURE	DATE

SUPERVISOR REVIEW

I have reviewed this application.

COMMENTS (Optional) - *Attach sheet if additional space is needed.*

SUPERVISOR'S SIGNATURE	DATE

(Forward to Division Payroll/Personnel after signing)

PERSONNEL/PAYROLL

LEAVE BALANCES AS OF (DATE):

ANNUAL LEAVE	SICK LEAVE	COMPENSATORY TIME	OTHER	DEPARTMENT HIRE DATE

Eligible for workers' compensation indemnity	☐ Yes	☐ No	Eligible for long term disability	☐ Yes	☐ No

PERSONNEL/PAYROLL REPRESENTATIVE SIGNATURE	DATE

FOR LEAVE SHARE COMMITTEE USE

TOTAL NUMBER OF HOURS APPROVED	DATE APPROVED	EFFECTIVE DATE

LEAVE SHARE REPRESENTATIVE SIGNATURE	DATE