ELIZABETH CITY STATE UNIVERSITY
VOLUNTARY SHARED LEAVE REQUEST FORM

SECTION I: TO BE COMPLETED BY EMPLOYEE

Date ____________________________

Name ____ Banner ID # _____________________

Division:____ Dept.:____________________________

Total Leave Requested ______________ Hrs.

Leave Balance: SICK ________ VACA ______ SHAR _______ BONUS _______

As of ____________________________

Date

(A Doctor's Statement should be forwarded to the Division of Human Resources)

I, ____________________________ , by my signature and application to participate in the Voluntary Shared Leave Program permit authorized personnel to release any leave information as deemed necessary to affect the above stated request within the guidelines set forth by policy. I acknowledge that I have 30 days to submit donated hours from the time of approval. Hours not received will result in negative hours being DOCK from my monthly payroll check.

SECTION II: ACKNOWLEDGMENTS

____________________________ ____________________________

Supervisor Date

____________________________ ____________________________

Human Resources (APPROVAL) Date

Revised 061611

ELIZABETH CITY STATE UNIVERSITY
VOLUNTARY SHARED LEAVE TRANSFER REQUEST FORM
Please complete this form and return to the Division of Human Resources & Payroll
Campus Box 944

I have agreed to donate leave to ____
who is participating in the Voluntary Shared Leave Program.

TO BE COMPLETED BY DONOR

Donor's Name ____ Banner ID# ___________________

Division ____ Dept. ________________________________

	SICK	VACA	BONUS	As of Date	Verified by HR
Beginning Leave Balance					
Leave Donated					
Ending Leave Balance					

Are you related by blood or marriage to the recipient? Yes ☐ No ☐
If yes, what is your relationship to the recipient? ____

By my signature, I give authorized personnel permission to transfer the amount ____________
hours from my leave to ____
Recipient's Name

____ ____

Signature Name

An employee of any agency, public school system, or community college may contribute vacation/bonus or sick leave to another immediate family member in any agency, public school or community college. This includes family members on leave without pay.

An employee may donate the following leave to a non-family member;

- *An employee may donate vacation or bonus leave to another employee in any State agency;*
- *An employee may donate vacation./bonus leave to a co-worker's immediate family who is an employee in a public school or community college. The employee & co-worker must be in the same agency. This includes non-family members on leave without pay.*
- *An employee of a State agency may donate sick leave to a non-family member of a State agency under the following provision effective January 1, 2011:*
  - *The donor shall not donate more than five days of sick leave per year to any one non-family member;*
  - *The combined total of sick leave donated from a non-family member donor shall not exceed 20 days per year;*
  - *Donated sick leave shall not be used for retirement purposes, and employees who donate sick leave shall be notified in writing of the State Retirement credit consequences of donating sick leave.*

For more information on the Voluntary Share Leave Program please review
Elizabeth City State University Policy 200.1.6

Revised 080311

Elizabeth City State University
Division of Human Resources & Payroll

VOLUNTARY SHARED LEAVE PROGRAM POLICY (200.1.6)
PHYSICIAN CERTIFICATION FORM

Authorization of Employee to Release Information

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to my employer, Elizabeth City State University, as it relates to my nomination and/or application for participation in the Voluntary Shared Leave Program. Elizabeth City State University shall review the merits of my application /nomination and this certification form to determine program participation eligibility.

I understand this information is to be furnished at no cost to my employer. Further, I certify that all answers are true and correct and understand that any misstatement is unlawful and may disqualify me from receiving benefits.

____________________________________ ________________________
Employee's Signature Date

Certification by Attending Physician

Note to Physician: Please complete this section and mail or fax to the address shown on reverse:

I hereby certify that I first treated ______________________________ for his/her present
Give Name of Patient (hereafter referred to as "Patient")

condition ____________________________ and that he/she will require absence from work for a

* prolonged period of time or for a prolonged medical condition beginning ________________________
Month Day Year

* *A prolonged period of time or a prolonged medical condition, for this process, is defined as lasting 20 consecutive work days.*

If the patient is not the employee who signed the Authorization to Release Information above, please furnish a detailed statement describing the medical care that the employee will be providing for the "patient".

____

____

____

For medical condition of employee: Is the employee able to perform the essential functions of his/her position during this period? (*see attached job description*)	☐ YES ☐ NO
For medical condition of employee: Have you treated the employee for a previous, but different, prolonged medical condition within the last 12 months?	☐ YES ☐ NO
For medical condition of family member: Is the employee's absence from work necessary for and/or beneficial to the care and recovery of this Patient?	☐ YES ☐ NO
For medical condition of family member: Have you treated patient for a previous, but different, prolonged medical condition within the last 12 months?	☐ YES ☐ NO
Period of time Patient is expected to be under medical care for this condition: (NOTE: Annual-recertification may be required for conditions lasting more than 1 year.)	From: To:
Period of time Employee is expected to be absent from work for this condition: (NOTE: Leave blank if absences are sporadic or intermittent.)	From: To:
Is patient's serious illness considered a Prolonged Medical Condition or Prolonger Period of Time?	☐ YES ☐ NO

Indicate the prognosis of Patient's serious medical condition. Check all that apply:	**Specify the duration and/or frequency of care that would require the Employee to be absent from work due to this serious health condition:**
☐ Condition requiring short-term incapacity / absence S*hort-term or sporadic conditions or illness.*	
☐ Condition requiring short-term treatment ***Short -term recurrence of chronic allergies or conditions***	
☐ Chronic condition requiring recurrent treatment S***hort-term absences due to contagious diseases***	
☐ Chronic condition requiring recurrent absence(s) ***Short-term recurring medical or therapeutic treatments***	
☐ Parental Care ***use for parental care of a newborn child with a documented prolonged health condition***	
☐ Incapacity due to complications of pregnancy	
☐ Other qualifying condition (Specify):	
None of the above / Does not qualify	

CERTIFIATION: I affirm that the information above is true and accurate to the best of my knowledge.

Physician's Name (print) Signature Date

Health Care Practice Phone No.

Address City State Zip Code

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When Completed, Please Mail or Fax to: **Elizabeth City State University**
Division of Human Resources & Payroll
Campus Box 944
Elizabeth City, NC 27909 **Fax: 252-335-3415**