NEW HANOVER COUNTY SCHOOLS

VOLUNTARY SHARED LEAVE APPLICATION

Employee's Name: ____

Social Security Number: ____

School/Department: ____

Position: ____

Serious Medical Condition requiring the need for additional leave: ______________________

____

____

____

Estimated amount of time needed: ____

*Voluntary Shared Leave donations will be accepted for only two weeks from the date of the publication of the request.

> *I authorize the New Hanover County Schools' Volunteer Shared Leave Committee to make known through system-wide communications my need for additional leave. Only general information about my condition is to be released beyond the Committee.*

______________________________ ______________________

Signature of Applicant ***Date***

Certification of Health Care Provider form must be submitted with the application to:
Heather Listebarger, Benefits Supervisor/Human Resources
6410 Carolina Beach Road
Wilmington, NC 28412

APPROVAL:

______________________________ ______________________

Benefits Supervisor ***Date***

______________________________ ______________________

Superintendent or Designee ***Date***

NEW HANOVER COUNTY SCHOOLS
6410 Carolina Beach Road
Wilmington, NC 28412

AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION

Employee's Name : ____
(Please print)

Social Security Number:____

I hereby authorize any physician, hospital, agency, or other organization to disclose to New Hanover County Schools any medical records or other information to support my request for Voluntary Shared Leave. I understand that a copy of this authorization will be considered to be as valid as the original.

____ ________________________
Signature of Applicant ***Date***
(or person acting on his/her behalf)

____
Street Address

_______________________________ _________ ___________
City State Zip Code

____
Phone Number

10/15/10

New Hanover County Schools

CERTIFICATION OF HEALTH CARE PROVIDER

To be completed by Health Care Provider

1. Employee's Name	2. Patient's Name (if other than employee)
3. Diagnosis	
4. Date condition commenced	5. Probable duration of the patient's incapacity **(Need a specific date)**

6. Regimen of treatment to be prescribed. Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment, if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or per week.

   a. By Physician

   b. By referred provider of health services

7. Is inpatient hospitalization of the employee required? ☐**YES** ☐**NO**

8. Is employee able to perform work of any kind? ☐**YES** ☐**NO**

9. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.) ☐**YES** ☐**NO**

For certification relating to the care of an employee's seriously-ill family member, complete items 10 thru 14 below as they apply to the family member.

10. Is inpatient hospitalization of the family member (patient) required? ☐Yes ☐No

11. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ☐ Yes ☐ No

12. After review of the employee's signed statement (see item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
☐ Yes ☐ No

13. Estimate the period of time care is needed or the employee's presence would be beneficial.

Item 14 to be completed by the employee

14. When leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

Employee Signature ______________________ Date ______________

Signature of Health Care Provider ______________________ Date ______________

Print Name of Health Care Provider ______________________ Telephone Number ______________

Type of Practice ______________________ License No. ______________

Address ______________________ City ______ State ______ Zip ______

Certification of Health Care Provider must be submitted to:

Heather Listebarger,Benefits Supervisor/Human Resources
6410 Carolina Beach Road
Wilmington, NC 28412
Fax: (910) 254-4129