BELLINGHAM PUBLIC SCHOOLS
Bellingham, Washington

5328F-1

M E M O R A N D U M

TO: Human Resources

FROM: _____
(Name of Employee -- Please print)

_____
Location

SUBJECT: Recipient of Shared Leave

Under the provision of RCW 28A.400.380, I wish to become an eligible recipient of shared leave days.

I have read and understand the criteria listed on the reverse side of this form which will be used in determining my eligibility to participate in this program, and I certify that I do meet those criteria. Specifically, I certify that:

1. I have exhausted or will exhaust all applicable vacation and/or sick leave and all other forms of paid leave;
2. I am not eligible for time loss compensation under the State Industrial Insurance Act (Chapter 51.32 RCW);
3. I accrue and am eligible to use sick leave and/or annual vacation leave;
4. I have abided by the District's policies regarding use of sick leave; and
5. The condition for which I seek shared leave has caused or is likely to cause me to go on leave without pay or to terminate my employment with the District if I do not receive shared leave.

I further certify that:

1. The name of the individual who is suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition is _____.
2. The person named in Paragraph 1. above is related to me as follows: _____, e.g., self, spouse, child, foster child, etc.
3. A physician's statement is attached, as required, verifying the "extraordinary or severe" nature of the illness which means "serious or extreme and/or life threatening."

_____ _____
Signature Date

FOR OFFICE USE ONLY:
Request Granted _____
Request Denied _____
Reason for Denial _____
Human Resources Signature/Date _____

DISTRIBUTION:
Business Manager
Payroll
Recipient
Recipient file if approved
Administrator

⇨⇨⇨

LEAVE SHARING RECIPIENT -- ELIGIBILITY REQUIREMENTS

The purpose of the leave sharing program is to enable employees to donate annual vacation leave or sick leave to a fellow employee who is suffering from or has a relative or household member suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition which has caused or is likely to cause the employee to take leave without pay or terminate his/her employment.

The following explanations are to be used to assist you in determining if you are eligible to participate as a recipient in the leave sharing program:

Definitions:

1. "Employee's relative" means the leave recipient's spouse, child, stepchild, grandchild, grandparent, parent, sibling, or other close relative by blood or marriage.
2. "Household members" means those persons who reside in the same home as a family unit. This term shall include foster children and legal wards even if they do not live in the household. The term does not include persons sharing the same general house when the living style is primarily that of a dormitory or commune.
3. "Extraordinary or severe" shall mean "serious or extreme and/or life threatening."

You are eligible to receive leave from a donor if you:

1. Accrue and are eligible to use sick leave and/or annual vacation leave.
2. Are not eligible for time loss compensation under the State Industrial Insurance Act (RCW Chapter 51.32).
3. Have abided by the District's policies regarding use of sick leave.
4. Have exhausted or will exhaust all applicable vacation and/or sick leave and all other forms of available paid leave.
5. The condition has caused or is likely to cause you to go on leave without pay or terminate your employment with the District.

The District shall determine the amount of shared leave a leave recipient may receive and will only authorize an employee to use up to a maximum of 261 days of shared leave during total statewide school district employment.

Any leave not used in connection with the specified and approved illness or injury will be returned to the donor or donors.

If you wish to proceed, please complete the request for shared leave form on the reverse side of this document. **A physician's statement must be attached verifying the severe or extraordinary nature and expected duration of the condition.** Please send the completed document with the required medical verification to the Human Resources Department.

Any additional questions concerning this should be directed to the Human Resources Department.

9-12-02