STATE OF KANSAS  
SHARED LEAVE PROGRAM  
Shared Leave Request Form

When completing forms please write legibly and be clear and thorough with explanations.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Employee ID#</th>
</tr>
</thead>
</table>

**PART I – To be completed by employee or employee’s representative**

<table>
<thead>
<tr>
<th>Name</th>
<th>Employee ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>SSN</td>
</tr>
<tr>
<td>(City) (State) (Zip)</td>
<td></td>
</tr>
<tr>
<td>Home Telephone</td>
<td>Work Telephone</td>
</tr>
<tr>
<td>Agency Name</td>
<td>Department ID#</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Employment</th>
</tr>
</thead>
</table>

| Request is for: Self | Family Member |

<table>
<thead>
<tr>
<th>Name of Family Member and explanation of relationship (please include age if child):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date illness/injury began:</th>
<th>Anticipated duration:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Estimate of number of hours requested:</th>
<th>Date all paid leave will be/was exhausted</th>
</tr>
</thead>
</table>

Shared leave will only be granted for serious, extreme, or life-threatening illnesses, injuries, impairments or physical or mental conditions which have caused, or are likely to cause, the employee to take leave without pay or terminate employment. Shared leave will not be granted for common or minor illnesses, injuries, impairments or physical or mental conditions. To be eligible for consideration, an employee must not have a history of leave abuse within the last year.

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical condition is serious, extreme or life-threatening:

**Are you currently receiving Worker’s Compensation?**

**Are you currently receiving Long-Term Disability Payments?**

**Have you applied for Worker’s Compensation?**

**Have you applied for Long-Term Disability Payments?**

I certify that I understand, agree to and meet the requirement and conditions of the shared leave program as authorized in K.A.R. 1-9-23. I authorize the appointing authority to obtain any necessary information regarding my request for shared leave and to share that information with the Shared Leave Committee. I understand that denial of this application is not subject to appeal to the Civil Service Board. **I declare under penalty of perjury that the foregoing is true and correct.**

Executed on date below.

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
When completing forms please write legibly and be clear and thorough with explanations.

Employee Name __________________________   Employee ID# __________________________

PART II – Licensed Health Care provider Statement.
IF THIS REQUEST IS FOR THE CARE OF A FAMILY MEMBER PLEASE INDICATE THE ROLE THEY WILL HAVE IN THE CARE.

Patient’s Name __________________________________________

Date first consulted for this condition __________________________

Describe the nature of the illness, injury, impairment or physical or mental condition (please attach documentation):

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

Describe the diagnosis of the illness, injury, impairment or physical or mental condition (please attach documentation):

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

Describe the treatment and prognosis of the illness, injury, impairment or physical or mental condition (please attach documentation):

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

_______________________________________________________________________________________________________

Anticipated duration the patient will be unable to work due to the condition: From __________ Through __________

Dates of hospitalization (if applicable): From __________ Through __________

Date of Surgery (if applicable): __________________________

Physician Name __________________________ Telephone Number __________________________

Address __________________________

______________________________  __________________________  __________________________
City  State  Zip
STATE OF KANSAS
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Employee Name __________________________   Employee ID# ________________
Licensed Health Care provider Signature _______________________________ Date ________________

PART III – To be completed by the Agency human Resource Office of Umbrella Agencies.

______ The employee has used, or will use all forms of paid leave including vacation leave, sick leave and compensatory time credits as of ____________.
______ The employee’s last day physically at work was ____________________.
______ The employee has six months of continuous service.
______ The Relationship meets the requirements set forth in K.A.R. 1-9-23 if the request is for the care of a family member. (Mark N/A if the request is for the employee.)

We certify that the employee meets all the initial eligibility requirements above and has maintained a satisfactory attendance and/or leave record within the past year.

Appointing Authority or Designee _______________________________ Date ________________

If an employee does not meet all the initial eligibility requirements or has not maintained a satisfactory attendance record, take no further action. File this request and notify the employee.

Please forward completed form to ATTN: Shared Leave Committee –c/o Jolene Flowers Office of Personnel Services, 915 SW Harrison, Room 451-S, Topeka, KS 66612 or fax to (785) 296-7712.

Please submit the name of person to be contacted with the committee decision. This will be done by e-mail which will also be your official confirmation for records.

E-mail reply to: ________________________________

PART IV – To be completed by Shared Leave Committee.

We have reviewed the request and make the following recommendation:

______ Approve
______ Deny – Does not rise to the level of being serious, extreme or life-threatening
______ Return for additional information/clarification What: ________________________________

______ Approve
______ Deny – Does not rise to the level of being serious, extreme or life-threatening
______ Return for additional information/clarification What: ________________________________

Shared Leave Committee Representative _______________________________ Date ________________

PART V – To be completed by the appointing authority

I hereby (please circle one) APPROVE DENY the use of shared leave for ________ hours through ____________
STATE OF KANSAS
SHARED LEAVE PROGRAM
Shared Leave Request Form

When completing forms please write legibly and be clear and thorough with explanations.

Employee Name __________________________   Employee ID# __________________

Appointing Authority Signature __________________________ Date ______________