**City of Tacoma**
Human Resources Department

Shared Leave Request Form

| EMPLOYEE'S INFORMATION | | | |
|---|---|---|---|
| Last Name: | First Name, Middle Initial: | Employee ID: | Hours/Work Schedule: |
| Location: | Division/Department: | Supervisor's Name: | |
| Would you like email correspondence be sent to a personal email address? ☐ **Yes** ☐ **NO**<br>If yes, please provide your personal email address: | | | |

| **EMPLOYEE ACKNOWLEDGEMENT AND SIGNATURE**: | **VERIFICATION REQUIREMENT:** |
|---|---|
| ☐ I am suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition. A "severe or extraordinary condition," is defined as serious or extreme and/or life threatening, as verified by a licensed physician or health care practitioner. | Along with this request, submit form Shared Leave Medical Certificate, completed by a licensed physician or health care practitioner, verifying the severe or extraordinary nature and expected duration of the condition. |
| ☐ I attest my absence has depleted or will shortly deplete all of my available accrued leave. Resulting in a need to take leave without pay (LWOP) or terminate my employment. I understand any shared leave may only be used by me for the reason specified on the Share Leave Medical Certificate. | |
| If I am approved to participate in the shared leave program, please ☐ **post**, ☐ **do not post** my name to the City's GNET/UNET website under "Employees Approved for Donated Leave" as well as other internal city communications that advertise this program. | |
| This request is due to an On the Job Injury (OJI) ☐ **Yes** ☐ **No**<br>I will receive time-loss compensation. ☐ **Yes** ☐ **No** | If you applied for time-loss compensation, and have been denied, or have exhausted your benefits you must supply verification. |
| ☐ I understand any shared leave I receive will be applied to when I first go into an unpaid status. | |
| ☐ I understand shared leave is not a supplemental benefit for the State's Paid Family Medical Leave (PFML) program. | If you are receiving PFML benefits, any shared leave you receive must be reported to the Employment Security Department (ESD). |

I request approval to participate in the Shared Leave Program for the reason selected above. As required, I have attached/submitted documentation verifying my qualifying reason.

*Any person who knowingly requests shared leave and provides false information or conceals for the purpose of misleading information concerning any fact material hereto, will be required to pay back to the City all, or portions of, monies received under the shared leave program. In addition, discipline, up to and including termination may be imposed. If you have a workers ' compensation appeal, pending while you are receiving shared leave, and your claim is ultimately allowed for time-loss purposes you will be required to reimburse the City all monies received under the shared leave program and all shared time will be reinstated to the donating parties.*

| Signature | Date |
|---|---|
| | |

| SUPERVISOR REVIEW | | |
|---|---|---|
| To the best of my knowledge, this employee has abided by department rule, policy, and/or applicable CBA regarding the use of sick and/or vacation leave?<br>☐ Yes ☐ No | | |
| Date | Print Name | Signature |

**RETURN COMPLETED FORM TO:**

Disability and Leave Management Office, City of Tacoma Human Resources Department
747 Market Street 1420 Tacoma, WA 98402 • Fax: (253) 591-5451 • Email Address: DLM@cityoftacoma.org

| DISABILITY AND LEAVE MANAGEMENT OFFICE REVIEW | | | | |
|---|---|---|---|---|
| Appropriate supporting documentation was submitted?<br>☐ Yes<br>☐ No | Meets eligibility criteria?<br>☐ Yes<br>☐ No | Type of leave needed:<br>☐ Intermittent<br>☐ Continuous | Eligibility Date: | End Date, if applicable: |
| Date | Print Name | Signature | | |

| HRMS USE ONLY | | | | | | |
|---|---|---|---|---|---|---|
| Annual Leave Balance: | Sick Leave Balance: | Personal Holiday Balance: | Comp. Leave Balance: | Date of Leave Balances: | Estimate when all leave balances will be ZERO **(Begin Date)**: | Estimate when a new request must be submitted **(End Date)**: |
| Date | Print Name | Signature | | | | |