WAKE COUNTY PUBLIC SCHOOL SYSTEM
VOLUNTARY SHARED LEAVE APPLICATION

Please enter all information completely.

Employee's Name: ____________________ Employee Number: __________

Employee's Address: ______________________________

Employee's Phone Numbers: Home: ______________ Work: ____________

School/Department: ______________________________

Position: ________________ Supervisor: ____________________

Leave Account Balance: ____ Sick: ____ Annual: ____ Compensatory Time: ______

From your check stub, please indicate the pay period for your balances: ___

Statement of medical necessity requiring the need for additional leave:

The combined total of sick leave donated to a recipient from non-family members shall not exceed 20 days per year. A doctor's statement must be attached to this application detailing the medical condition and certifying the length of time needed before the application will be considered.

Employee Statement: I, ______________________________

request consideration for Voluntary Shared (Donated) Leave due to the above mentioned medical condition. I hereby authorize the Wake County Public School System to make known through site-based communications my need for additional leave upon completion of this application and written notification to my supervisor. I understand that I may not solicit, force or coerce any individual into donating leave. The donation of leave under this program shall be entirely voluntary. I further understand that if I directly or indirectly solicit, use force, coerce or give or receive compensation for voluntary shared leave,-I will be subject to disciplinary action up to and including dismissal as outlined in N.C.G.S §155C-325.

______________________________ ______________________________

Employee's Signature/Date **Supervisor's Signature/Date**

Human Resources Administrator's Approval: ____________________ **Date:** ________

Revised March 2015