BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

Shared Sick Leave Program – Request Form

USG Institution Name: **Albany State University**

Employee Name: _____ Employee ID:_____

Contact#: _____ Email:_____

Department: _____ Supervisor:_____

I am requesting _____hours of Shared Leave under the terms specified in the Shared Sick Leave Program Policy.

I hereby acknowledge and certify the following:

- I am an active member of the Shared Sick Leave Program.
- I have enclosed a completed physician's certification of a serious health condition for myself or an immediate family member.
- I agree that I will notify the Office of Human Resources if I am approved for other benefits (i.e., Workers Compensation, Short or Long Term Disability, Social Security Insurance, Disability Retirement, etc.) prior to or after I begin receiving donated sick leave.
- I acknowledge that I have read and understand the program provision as set forth in the Shared Sick Leave Program policy.
- I understand that documentation of having a Power of Attorney is required with this form if I am acting on behalf of the employee recipient.

_____ _____

Date Medical Condition Began Date Medical Condition is Expected to End

_____ _____

Signature of Recipient (Authorized Representative) Date

INSTRUCTIONS: Please complete and return this Shared Sick Leave Request form and the Physicians Certification form to your Office of Human Resources.

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FOR USE BY THE OFFICE OF HUMAN RESOURCES

Type of Request: Initial Request _____ Secondary Request: _____

Status of Request: Leave Request Approved ____ Leave Request Not Approved ____

Your request for donated leave cannot be accepted due to the following reasons:

_____

_____

_____ _____

Shared Sick Leave Program Administrator Signature Date

If this request is denied and you wish to appeal this decision, submit your appeal along with this notice, in writing to the Office of Human Resources- Shared Sick Leave Program Administer.