**Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hire Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-time Equivalent (FTE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (40 hrs./week = 1.0, 30-40 hrs./week = .75, 20-30 hrs./week =.50)\*

I have successfully completed my provisional period: \_\_\_\_\_\_\_\_\_ (initial here)

Serious Health Condition for: [ ]  Employee \_\_\_ [ ]  Immediate Family Member

I have read and understand the Shared Sick Leave Policy. \_\_\_\_\_\_\_\_ (initial here)

I wish to donate \_\_\_\_\_\_\_\_\_\_ hours of sick leave (8 hour minimum and 80 hour maximum) (pro-rated for part- time employees) to be used as part of the Shared Sick Leave Program. The leave will be transferred to the sick leave pool effective January 1st, unless otherwise notified.

I hereby acknowledge the following:

* I agree that my donation is strictly voluntary.
* I understand that I must donate a minimum of eight (8) hours and retain at least 40 hours of sick leave in my own account when donating sick leave. Hours are pro-rated for part-time employees.
* I agree that the hours that I am donating have already been accrued.
* I understand that after my leave donation has been charged against my leave balance, it is irrevocable and cannot be withdrawn.
* I understand that if the leave pool is depleted, I will be notified and automatically charged eight (8) hours, unless I wish to withdraw at that time.

I have read and understand the policies related to GHC’s Shared Sick Leave Program and agree to participate by signing my name and dating below.

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Employee Signature**  **Date**

I authorize the following family members to apply for Shared Sick Leave on my behalf if I am unable to do so.

|  |  |
| --- | --- |
| **Name (print)**  | **Relationship**  |
|  |  |
|  |  |

**FOR USE BY THE SHARED SICK LEAVE PROGRAM ADMINISTRATOR**

**Transfer Approved**  (keep in employee benefits file) **Transfer Denied**  (return to employee, keep copy in employee benefits file) Your request to donate leave cannot be accepted due to the following reason(s):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Shared Sick Leave Administrator/Date** **Payroll/ Date**