PART A

SHARED LEAVE REQUEST FORM

I, ____________________________________, request to receive shared leave in accordance with WAC 357-31-390(1) (a – f), 357-31-400 and RCW 41.04. I'm requesting shared leave for □ myself or □ for a relative/household member.

If requesting for a relative/household member, please complete the following:

Relative Name:  
Relationship:  
Household Member Name:  
Explain:  

All of my leave, (vacation, sick, personal holiday and compensatory), has been or will be exhausted (except in cases of Parental Leave or Illness or Temporary Disability due to Pregnancy, where requester MAY maintain 40 hours of both sick and vacation) and I am or will be in a leave-without-pay status.

_________________________ ________________________  
Signature        Date

This form must be accompanied by a medical certification from a licensed physician stating the reason for absence, the medical problem and the expected return to work date for those requests that involve illness. You must have your physician fill out the bottom portion of this form to qualify for medical shared leave.

PART B

MEDICAL CERTIFICATION

I certify that ___________________________ is a patient of mine and it will be necessary for the Olympic College employee ___________________________ to be absent from work for _______ days due to the following condition:

______________________________________________________________________________________________________________________________  
______________________________________________________________________________________________________________________________  
__________________________________________________________________________________________

The RCW defines eligibility criteria for shared leave as follows: Employee suffers from, or has a relative or household member suffering from an illness, injury, impairment, or physical or mental condition which is of an extraordinary or severe nature.

Does the patient’s condition meet the eligibility criteria as defined by the RCW?  
___ YES  ___ NO

_________________________ ________________________  
Signature of Attending Physician        Date

_________________________ ________________________  
Approval of Olympic College Human Resources        Date

Revised 1/30/2020