Voluntary Shared Leave Application

Name of Recipient____

Employee ID __________________

Division/Section ________________ **Position/Title**___________________________

Supervisor _______________________________ **Supervisor Phone** __________

Leave requested for ☐ Employee

☐ Immediate Family (state Relationship)

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GENERAL MEDICAL CONDITION (ATTACH PHYSICIAN STATEMENT)

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VACATION LEAVE BALANCE _____________

SICK LEAVE BALANCE _____________

BONUS LEAVE BALANCE _____________

EMPLOYEE'S AUTHORIZATION
I, ___________________________, HAVE REQUESTED, OR HAVE BEEN NOMINATED, TO RECEIVE LEAVE UNDER THE PROVISIONS OF THE VOLUNTARY SHARED LEAVE POLICY OF THE STATE OF NORTH CAROLINA , AND HEREBY AUTHORIZE THE DISCLOSURE OF MY NEED FOR DONATED LEAVE.

RECIPIENT'S SIGNATURE _________________________DATE___________________

For Human Resources Staff Use Only

AMOUNT OF LEAVE RECEIVED: VACATION_________SICK___________BONUS________
AMOUNT OF LEAVE RETURNED: VACATION ________SICK ___________BONUS________
APPROVED____ NOT APPROVED____ SIGNATURE____________________DATE_________
ACCOUNT CLOSED ____

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