# SHARED LEAVE REQUEST FORM

Requests for Shared Leave must be due to a medical emergency that is serious, extreme or life threatening, which has made you unable to work and experiencing a substantial loss of income.

**To request Shared Leave, please complete all fields of this form. Once completed, you may either:**

- Save this forms and email to: Human.Resources@gfcounty.org Electronic signatures are acceptable.
- Print, sign and interoffice it to the Department of Human Resource or by fax: (701) 335-7521.

## EMPLOYEE INFORMATION

First Name _____ Last Name _____ Last four digits of SSN _____

Department _____ Email _____ Phone Number _____

Date all paid leave will be/was exhausted _____ Number of Hours Requested _____ Date of Hire _____

**The reason I am absent is due to:**

☐ my own medical condition ☐ to care for a family member Name and Relationship _____

Are you receiving Workers' Copmensation payments? ☐ Yes ☐ No

Are you receiving disability or wage replacement payments? ☐ Yes ☐ No

## TERMS AND CONDITIONS

1. I understand if my leave of absence is not a FMLA leave, I will still need to provide certification from a medical provider.
2. I understand that I cannot be receiving Workers' Compensation Insurance or any disablity or wage-replacement payments.
3. I understand that I must exhaust all of my paid leave available, including personal holidays, wellness hours and compensary time.
4. I understand that there is a five (5) day waiting period of unpaid leave prior to receiving Shared Leave.
5. I understand that if I receive Shared Leave, it will be considered gross income and wages for purposes of FICA, FUTA and income tax withholding.
6. I understand that my request will be reviewed by the Shared Leave Committee and their decision to approve or deny my request of Shared Leave is final and not subject to appeal. However, I may submit additional medical information for second consideration.
7. I understand that I cannot coerce, threaten or intimidate another employee to donate hours.
8. I understand that the maximum amount of Shared Leave that I can receive is 160 hours.
9. I understand that there is no guarantee as to the number of hours of Shared Leave will be provided.

## EMPLOYEE SIGNATURE AND ACKNOWLEDGEMENT

I understand and agree to the terms and conditions of the SHARED LEAVE POLICY. I authorize the appointing authority to obtain any necessary information regarding my request for shared leave. I understand that if I give false or misleading information to secure Shared Leave or attempts to intimidate, threaten, or coerce another employee with the respect to donating VACATION OR SICK leave, my request will be denied and disciplinary action, up to and including termination may occur.

SIGNATURE OF EMPLOYEE: _____ DATE: _____

## FOR HUMAN RSOURCES AND PAYROLL USE ONLY

Date Received: _____ Received by: _____ Committee Review Date: _____

☐ Approved Last day of paid leave: _____ Total Shared Leave Approved: _____ ☐ Denied

GRAND FORKS COUNTY
HEART OF THE RED RIVER VALLEY

Human Resources Department

# VOLUNTARY SHARED LEAVE PROGRAM
# PHYSICIAN CERTIFICATION FORM

## AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize the undersigned medical provider to release medical information to my employer, Grand Forks County, as it relates to my application for participation in the Voluntary Shared Leave Program. Grand Forks County shall review information provided exclusively to determine program participation eligibility.

_____ _____
Patient's Signature Date

☐ This authorization is for an employee of Grand Forks County.

☐ This authorization is for a family member, ☐ spouse, ☐ child, ☐ parent, of an employee of Grand Forks County.

## MEDICAL PROVIDER CERTIFICATION

**Note to Medical Provider:** Please complete and return via confidential fax (701) 335-7521.

I hereby certify that I am currently treating, _____ ,for their present medication
(Patient's Name)

condition _____ and that the
(brief description of condition)

employee will be required to be absent from work until _____.

| | |
|---|---|
| **Do you consider this medical condition serious, extreme or life threatening?** | ☐ Yes ☐ No |
| **For medical condition of the employee:** Is the employee able to perform the essential function of their position during this period? *(see attached job description)* | ☐ Yes ☐ No |
| **For medical condition of family member**: Is the employee's absence from work necessary to the care and recovery of this patent? | ☐ Yes ☐ No |

Please furnish a detailed statement describing the medically related care that the employee will be providing for the patient.

_____

_____

_____

## MEDICAL PROVIDER INFORMATION

| | |
|---|---|
| SIGNATURE OF HEALTH CARE PROVIDER | DATE |
| Medical Provider Name | Phone: ( ) - |
| Address | City/State/Zip |

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.