Shawnee Public Schools

Sick Leave Sharing Program Request

Today's Date_____ School Name/Site #_____

Name_____ SSN# _____

HAVE YOU, OR WILL YOU EXHAUST ALL EARNED SICK LEAVE?_____

You must have a physician complete the certification on the reverse side of this form. Please note that this leave will run concurrently with FMLA.

I hereby certify that, to the best of my knowledge, I have previously abided by the district's leave policies; that the nature of the condition is such that I have used or will use all accumulated sick leave available to me; and that the condition has caused or is likely to cause me to take leave without pay or to terminate employment.

Signed_____ Date_____

APPROVAL/DISAPPROVAL

Request for donated Sick Leave is approved_____not approved_____

Healthcare Certification is not complete. _____

Employee's Condition does not meet definition of
Extraordinary or severe as defined in Board Policy DEFA. _____

Employee has sick leave available. _____

Superintendent or Designee Signature_____Date_____