KANSAS JUDICIAL BRANCH
SHARED LEAVE PROGRAM
Shared Leave Request Form

PART I - To be completed by employee.

Name ______________________________ Employee ID# ____________________

Home Address ______________________________ SSN ____________________

____
(City) (State) (Zip)

Home Telephone ____________________ Work Telephone ____________________

Judicial District/County ________/______________________________

Work Address ____

____
(City) (State) (Zip)

Date of Employment ____________________
(mm/dd/yy)

Date illness/injury began: ____________________
(mm/dd/yy)

Number of hours requested: ____________________ Date all paid leave will be/was exhausted____________________
(mm/dd/yy)

Shared leave is intended to be granted only to employees who, because of illness or injury, are unable to work for an extended period of time (exceeding 180 days) and who have in good faith applied for long term disability benefits.

Describe and provide any necessary information that would help in concluding the medical condition is serious:

Have you applied for Worker's Compensation? ____________________ Date Applied ____________________
(mm/dd/yy)

Are you currently receiving Workers Compensation? ____________________

Have you applied for KPERS Long-Term Disability payments? ____________________ Date Applied ____________________
(mm/dd/yy)

My name may _______ may not ______ be used to request donations of leave.

I certify that I understand, agree to, and meet the requirements and conditions of the shared leave program as authorized in Kansas Court Personnel Rule 8.15. I authorize the Administrative authority to obtain any necessary information regarding my request for shared leave. I understand denial of this application is not subject to appeal.

____
Employee Signature Date

Shared Leave Request Form

____
Employee Name Employee ID#

PART II - To be completed by the administrative authority (check all that apply).

If the employee meets all initial eligibility requirements below, the administrative authority approves or denies the use of shared leave.

I have made proper inquiry and find:

________ The employee has used, or will use all forms of paid leave including vacation leave, sick leave, discretionary day, and compensatory time credits as of ________________________________.
(mm/dd/yy)

The employee's last day physically at work was ________________________________.
(mm/dd/yy)

________ The employee has six months of continuous service with the Judicial Branch.

________ The employee has applied for KPERS Long-Term Disability.

________ The employee will be unable to perform regular work duties for at least 180 days.

________ The employee meets all the initial eligibility requirements above.

________ The employee does not meet all the initial eligibility requirements: take no further action. File request and notify employee he or she is not eligible for shared leave.

I hereby approve _______________ deny _______________the use of shared leave hours through ______________________________
(mm/dd/yy)

____
Administrative Authority Signature Date

Shared Leave Request Form

Employee Name ____________________ Employee ID# ____________________

PART III - Attending Physician's Statement.

Patient's Name ____

Date first consulted for this condition ____________________
(mm/dd/yy)

Describe the nature, diagnosis, and treatment of the medical condition (please attach documentation, if necessary).

When is it likely the patient may return to regular job duties?

Physician Name ______________________________ Telephone Number ____________________

Address____

____
(City) (State) (Zip)

Physician Signature ______________________________ Date____________________