WASHINGTON STATE UNIVERSITY

SHARED LEAVE

EMPLOYEE REQUEST

Pregnancy Disability or Parental Leave

Please return form to: WSU Human Resource Services
Office Location: (HRS) 139 French Admin.
OR Mailing address: PO Box 641014
Pullman, WA 99163-1014

Fax: 509-335-1259
Questions? Call HRS at: 509-335-4521

Use this form to apply for Shared Leave (SHL) for Pregnancy Disability and/or Parental Leave. Return this form to the Human Resource Services Pullman office along with the supporting documentation as described below.

A EMPLOYEE INFORMATION (please print)

Name of Employee (Last, First, MI)	WSU ID #
Personal Email	Personal Phone #

Leave balances reported on last time/leave report

Please Note: Employees are not required to deplete all of their annual and sick leave, and may maintain up to 40 hours of annual leave and 40 hours of sick leave in reserve.

Time/Leave Report Month (MM/YYYY)	Annual Leave Balance	Sick Leave Balance

Have you used your personal holiday for this year ☐ Yes ☐ No

B LEAVE REQUEST PERIOD

☐ I am requesting full-time leave from_____/_____/_____through_____/_____/_____

☐ I am requesting to reduce my work schedule from #_____hours to #_____hours per day/week beginning _____/_____/_____through_____/_____/_____

☐ I am requesting an intermittent work schedule from_____/_____/_____through_____/_____/_____or other schedule as described below (describe):

C SUPPORTING DOCUMENTATION

If verification is required, please provide one of the following to HRS.

☐ Pregnancy Disability
☐ Parental Leave

If you have not submitted documentation regarding your need to take leave to HRS, you will be asked to provide certification.

D ANNOUNCEMENT OF SHARED LEAVE

If request is approved: ☐ I DO consent ☐ I DO NOT consent

To the publication of my name in a WSU announcement noting my need for SHL donations.

E EMPLOYEE SIGNATURE

I understand it may be necessary for WSU representatives to share this information for purposes related to establishing eligibility for SHL. I authorize WSU to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether SHL is necessary and to administer the SHL process. I understand that information obtained under this release is a confidential medical record and is maintained separately from my personnel file.

I also certify that I meet all the requirements necessary for SHL as defined in RCW§41.04.665.

By signing below I acknowledge that I have read and agree to the above.

Employee Signature	Date