This form is to be completed by the employee requesting Voluntary Shared Leave and submitted to his or her Supervisor/Department Head for approval. If the employee is out of work and unable to complete this form, the supervisor/department head may complete on his or her behalf. If the form is completed by the supervisor or department head, a completed Nomination Form must accompany this application. The employee and supervisor and department head will receive a copy of the application decision. Submit completed form to Human Resources.

|  |  |
| --- | --- |
| TO: | Human Resources |
| FROM: |  |
| ID Number: |  |
| **SUBJECT:** | **Application for Voluntary Shared Leave** |
| DATE: |  |

I am requesting Voluntary Shared Leave due to:

|  |  |
| --- | --- |
|  | My own serious health condition |
|  | Parent |
|  | Child |
|  | Spouse |
|  | Military Caregiver Leave |

|  |  |
| --- | --- |
| Leave will begin or began on (mm/dd/yyyy) |  |
| and I expect leave to continue until (mm/dd/yyyy) |  |

**CERTIFICATION OF PHYSICIAN FORM** is on file with the Benefits Office in HR.  Yes  No

**If No**, please have your Health Care Provider complete Part II of the Family Medical Leave – Certification Form.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employee’s Signature |  | Date |
|  |  |  |
| Supervisor/Department Head Approval Signature |  | Date |

**FOR HUMAN RESOURCES USE ONLY:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Eligible/Approved - Employee meets all requirements for Voluntary Shared Leave per UNCG Policy. | | |
|  | Ineligible – Employee does not meet all requirements for Voluntary Shared Leave per UNCG Policy. | | |
|  | |  |  |
| Human Resources Signature | | | Date |