APPLICATION FOR LEAVE SHARING PROGRAM

Please direct all completed applications and questions to:

Leave Sharing Chairperson
Office of Labor Relations
University of Colorado at Boulder
565 UCB
3100 Marine Street, 3rd Floor
Boulder, CO 80309-0565
Phone: 303-492-0956
Fax: 303-735-3236

The Leave Sharing Committee is unable to evaluate an employee’s application for leave sharing until all of the items in the foregoing checklist are completed and sent to the Leave Sharing Chairperson.
Thank you for your cooperation!

Leave Sharing Application Checklist

1. **Responsibility of Applicant**
   - ☐ Part I fully completed and signed by employee
   - ☐ Personal Statement from employee attached
   - ☐ Completed Family Medical Leave (FML) Medical Certification attached
   - ☐ Part IV fully completed and signed by the employee’s or employee’s family member’s healthcare provider

2. **Responsibility of Appointing Authority**
   - ☐ Part II fully completed and signed by Appointing Authority

3. **Responsibility of Payroll Liaison**
   - ☐ Part III fully completed and signed by Payroll Liaison
   - ☐ Employee’s yearly leave records for current and last fiscal year attached
PART I - To be completed by Applicant:

A. Please attach a personal statement to this application describing the reason you are requesting leave sharing hours.

B. Please complete the following:

Check one:

☐ Classified Employee  ☐ Officer  ☐ Exempt Professional
☐ Instr. Faculty on 12 mo. appointment  ☐ Research Faculty on 12 mo. grant-funded appointment

Check one:

☐ UCB employee  ☐ System Administration employee

Name ___________________________________  Employee ID # __________________
Department _______________________________  Campus Box _____________________
Work Phone ______________________  Job Title/Classification ________________________
Email Address ____________________________________________

University Hire Date ___________________  Current % of FTE ___________________

Home Address: Street ____________________________

City, State and Zip _____________________________

Home Telephone _____________________________

Request is for care of:  Self _______ Family Member _______ Other _______ (Specify)

Anticipated duration of applicant’s absence from work:
Start date ___________________  Estimated return date ___________________

Number of leave sharing hours requested ___________________________

Complete all that apply:

Date FML applied for (attach medical certification) ______________ Approval date ______________

Date Short-Term Disability applied for ______________ Approval date ______________

Date Worker’s Compensation applied for ______________ Approval date ______________

Date PERA Disability/Retirement applied for ______________ Approval date ______________

Date Long-Term Disability/Retirement applied for ______________ Approval date ______________

I hereby certify that I understand, agree to, and meet the requirements of the Leave Sharing Program. I understand that any decisions made with respect to this application are not subject to grievance or appeal. My signature below indicates that I will use leave sharing hours only for the condition stated in this application and agree to return any leave sharing hours not used in connection with the stated condition.

________________________________________  __________________________
Signature of Employee  Date
PART II - To be completed by Applicant’s Appointing Authority (or Supervisor for Research Faculty):

Appointing Authority (Supervisor) Name:_________________________________________

Appointing Authority (Supervisor) Title: _________________________________________

Telephone Number: _______________     Campus Box: ___________________

Please answer the following questions:

1. Has this employee ever received any kind of corrective or disciplinary action for leave abuse?
   □ Yes □ No □
   Please Explain:

2. Is there any additional information you would like the Committee to consider in evaluating this application?

My signature below indicates that I approve this application and understand that my department is fiscally responsible for any hours awarded to this employee and that any hours awarded are to only be used in connection with the condition stated in this application.

__________________________________________________________________________
Signature of Appointing Authority (or Supervisor for Research Faculty)     Date

PART III - To be completed by Applicant’s Payroll Liaison:

Payroll Liaison Name:_____________________________________________________

Telephone Number: _______________     Campus Box: ___________________

Please answer the following questions:

1. Has this employee exhausted all sick and annual/vacation leave and compensatory time? □ □ Yes □ No
   a. If YES, when was leave/comp time exhausted? _________
   b. If NO, fill in the following information:
   As of ________ (insert date), applicant has:
   ______ hours of annual/vacation leave ______ hours of sick leave ______ hours of compensatory time.

My signature below indicates that I have attached copies of the applicant’s annual leave record forms for the current and prior fiscal year, and understand that if this application is approved, I am responsible for making the adjustments into the HRMS system and department records. I agree to accurately track leave sharing hours so that such hours are only used in connection with the condition stated in this application.

__________________________________________________________________________
Signature of Payroll Liaison                              Date
PART IV—To be completed by Attending Healthcare Provider for Applicant or Applicant’s Family Member:

Healthcare Provider’s Name______________________________________________ Telephone ______________

Address: Street__________________________________________________________

City, State and Zip________________________________________________________

Please review Genetic Information Non-Discrimination Act (GINA) Disclosures on the next page and then provide detailed responses to the following questions:

1. What is the patient’s illness/injury? _____________________________________________

2. When was the illness/injury diagnosed? ___________________________________________

3. Does the illness/injury pose a direct threat to the patient’s life?
   
   ☐ Yes (and check all that apply)
   ☐ the patient’s illness/injury itself is life-threatening
   ☐ a medical procedure the patient had/has to undergo as a result of the illness/injury is life-threatening
   ☐ the patient suffered a life-threatening complication as a result of his/her illness/injury or a medical procedure that he/she had to undergo
   ☐ if the patient does not seek immediate treatment, his/her condition will become life-threatening

   ☐ No

   Please Explain:

4. Will/did the patient’s illness/injury require inpatient, outpatient, hospice or residential care (either at a facility or in patient’s home)?
   
   ☐ ☐ Yes
   ☐ ☐ No

   Please Explain:

5. Will/did the patient experience a period of “incapacity” of 30 consecutive days or more due to his/her condition? (“Incapacity” means that the patient is substantially limited in performing activities in his/her daily life which he/she can normally perform. For example, the patient is substantially limited in seeing, speaking, hearing, breathing, sitting, standing, walking, lifting, reading, learning, performing cognitive tasks, feeding, bathing, dressing or grooming him/herself.)
   
   ☐ ☐ Yes
   ☐ ☐ No

   Please Explain:

6. If the employee will be providing care for the patient, what is the type and frequency of care needed?

______________________________  ______________________________
Signature of Healthcare Provider   Date
Genetic Information Nondiscrimination Act of 2008 (GINA) Disclosure Statement

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. However, please be advised that GINA Title II does allow you to provide information about the medical condition of an employee’s spouse, parent, child, legal dependant or person in the home for whom they are a primary caregiver, in order to substantiate the need for leave under CU-Boulder’s leave sharing program.