DA 325 (Revised 12/21) **COMMITTEE**

STATE OF KANSAS
SHARED LEAVE PROGRAM
Shared Leave Request Form

When completing forms please write legibly and be clear and thorough with explanations.

Employee Name _____ Employee ID# _____

PART I – To be completed by employee or employee's representative

Name _____ Employee ID # _____

Home Address _____ SSN _____

_____

(City) (State) (Zip)

Home Telephone _____ Work Telephone _____

Agency Name _____ Department ID# _____

Date of Employment _____

Request is for: Self _____ Family Member _____

Name of Family Member and explanation of relationship (please include age if child):

_____

Date illness/injury began: _____ Anticipated duration: _____

Estimate of number of hours requested: _____ Date all paid leave will be/was exhausted _____

Shared leave will only be granted for serious, extreme, or life-threatening illnesses, injuries, impairments or physical or mental conditions which have caused, or are likely to cause, the employee to take leave without pay or terminate employment. Shared leave will not be granted for common or minor illnesses, injuries, impairments or physical or mental conditions. To be eligible for consideration, an employee must not have a history of leave abuse within the last year.

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical condition is serious, extreme or life-threatening:

_____

_____

_____

Are you currently receiving Worker's Compensation? _____
Are you currently receiving Long-Term Disability Payments? _____
Have you applied for Worker's Compensation? _____ Date Applied: _____
Have you applied for Long-Term Disability Payments? _____ Date Applied: _____

I certify that I understand, agree to and meet the requirement and conditions of the shared leave program as authorized in K.A.R. 1-9-23. I authorize the appointing authority to obtain any necessary information regarding my request for shared leave and to share that information with the Shared Leave Committee. I understand that denial of this application is not subject to appeal to the Civil Service Board. **I declare under penalty of perjury that the foregoing is true and correct.** Executed on date below.

Employee Signature _____ Date _____