Print Form Clear Form

Attachment 470.4

UNIVERSITY OF HAWAI'I
LEAVE SHARING REQUEST FORM TO CARE FOR A FAMILY MEMBER

Name: _____ BU Code: _____
Last First Middle Initial

UH Username or No.: _____ Job Title: _____

Campus/School/Program: _____

E-Mail Address: _____ Daytime Phone No.: _____

I have received shared leave credits at UH: ☐ No ☐ Yes, when _____

Name of Family Member: _____ Relationship: _____

I am requesting approval to receive _____ hours or _____ days of shared leave for use from _____ to _____

Specify option(s): ☐ Direct Share* ☐ Central Leave Bank

*I authorize the campus/school/program to disclose my name and send out an email seeking leave donations on my behalf to employees of my campus/school/program.

Describe the illness/injury of family member that meets the definition of serious personal illness or injury and the reason you need to provide care: _____

_____

APPLICANT'S CERTIFICATION:

I have attached the UH Form 99, Certification of Physician to Care for a Family Member, certifying that my family member has a serious illness/injury and incapable of self-care. I attest that I will be providing the full-time, primary care necessary during the above stated period. I have exhausted or about to exhaust all vacation leave, compensatory time and sick leave credits allowable under the family leave law. I understand that any approved leave credits are to be used only for the purpose stated above. I further understand that falsification of information in this statement, or failure to notify the University of changed circumstances may lead to disciplinary action against me, which may include termination.

_____ _____
Employee's Signature Date

(CAMPUS/SCHOOL/PROGRAM TO COMPLETE)

The employee is caring for a family member that is suffering from an illness or injury that is life threatening or critical, severe, debilitating and catastrophic in nature that caused the employee to be absent from work for at least thirty (30) consecutive days. The employee has been employed in a position with at least in a fifty percent full-time equivalency for at least six (6) continuous months; exhausted, or will exhaust, all vacation leave, compensatory time and sick leave credits allowable under the family leave law; has no disciplinary record of sick leave abuse; has no unresolved outstanding salary overpayment obligations; and is not supported with federal funds. If this is a request for shared leave credits from the Central Leave Bank, I understand that this is a recommendation.

☐ Approve this request. The employee's absence will not result in any undue hardship on operational needs.
☐ Partially approve this request from _____ to _____ (reason for partial approval is attached).
☐ Deny this request (reason for denial is attached).

_____ _____
VP/Chancellor/Dean/Director or Designee Date