NORTHEASTERN STATE UNIVERSITY

Leave Share Program
Recipient Application

I, _____, request participation in the Northeastern State University Leave Share Program. I hereby certify that I, or a member of my immediate family (as defined by University policy), am suffering from a catastrophic or life threatening illness, injury, impairment, or physical or mental condition which has caused or is likely to cause me to take leave without pay or terminate employment. (Please attach medical documentation.) I understand that I must exhaust all earned leave balances before leave donations will be used.

Job Title Work Location/Department

_____

Signature Date

Print & Save

RECIPIENT'S ELIGIBILITY VERIFICATION

Leave balances as of _____ (date):

_____ hours Personal Leave

_____ hours Vacation

Verified by _____ on _____ (date)

DISAPPROVED Reason for disapproval_____

APPROVED _____ _____

Authorized Signature Date