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

☐ I hereby give permission to disclose my name, should a possible donor wish to know the person to which their time will be contributed. (OPTIONAL)

_____ _____
Signature Date

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