ARAPAHOE COMMUNITY COLLEGE
CLASSIFIED ANNUAL LEAVE SHARE PROGRAM
Application for Use of Transferred Leave

Part I – To be completed by the classified employee (please type or print legibly).

Name _____ Employee S# _____

Home Address/City/Zip _____

Home Telephone _____ Work Telephone _____

Job Title _____
Full Time _____ Part Time _____ % Appt _____

I hereby certify that I understand, agree to, and meet the requirements and conditions of the leave transfer program. I also hereby authorize the College President or his/her designee to obtain any necessary information concerning this application. I understand that denial of this application is not subject to grievance or appeal.

Signature of Employee _____ Date _____

Part II – To be completed by Human Resources.

Date Benefit Eligible Employment began _____ Monthly Salary _____

Has employee requested/applied for: Worker's Comp ___ ____ FMLA _____ LTD _____ PERA Disability _____

Is Medical Certification verifying catastrophic illness on file? Yes _____ No _____

Date illness/injury began _____ Anticipated duration _____

Date all sick leave will be/was exhausted _____ Number of days or hours needed _____

Signature of Human Resources _____
Date _____

Part III – To be completed by Supervisor.

Authorization to request donated leave is:
___*Approved* ___*Denied* Signature of Supervisor _____ Date _____

___*Approved* ___*Denied* Signature of President _____ Date _____

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Leave Contribution Record

Please type or print legibly.

Name _____ Employee S# _____
(first) (last)

Full Time ___ Part Time ___ %Appt ___ Job Title _____

Work Unit _____ Work Phone _____

Work Address _____

Number of hours donated _____ To (Employee/Case#): _____

I understand that my contribution is voluntary and that my balance of annual leave will be decreased by the amount contributed. I certify that my contribution will not result in a negative leave balance. I understand that my contribution is confidential.

_____ _____
(Signature) (Date)

For College/HR Use:

The above named employee's leave balance has been reduced by _____hours of annual leave.

_____ _____
(Authorized College/HR Signature) (Date)