City of Mission
Sick Leave Sharing Request

********************* EMPLOYEE INFORMATION********************

Date of Request: ________________________________ Employee No: ____________

Employee Name: ____
(First Name) (Last Name) (M)

Job Title: _________________________________ Department: _____________________

# of Hours Requesting: ____________________ FMLA Start Date: ________________

************* SICK LEAVE SHARING REQUIREMENTS ************

Pursuant to the Sick Leave Sharing policy (Policy No. 600.07), in order to qualify for the use of Sick Leave Sharing hours, the following requirements must be met:

☐ YES ☐ No Employee must be on approved family and medical leave.
☐ YES ☐ No Employee must have exhausted all available leave hours.

******************* EMPLOYEE CERTIFICATION *******************

I hereby certify that the information on this Sick Leave Sharing Request form is a true representation of my own/family member's illness/injury. I have exhausted all accumulated sick leave, vacation leave, and compensatory time at the time of this request. I am not requesting Sick Leave Sharing hours for an incident covered by workers' compensation. I have read and understand the rules pertaining to this policy. I further understand that falsification of this request or my failure to abide by the policy guidelines shall be automatic grounds for denial or termination of program participation.

Employee Signature: ___________________________________ Date: ____________

Forward the completed Sick Leave Sharing Request form to the Human Resources Director

************* HUMAN RESOURCES DEPARTMENT *************

Received By: ____ Date: ____________

HR Recommendation: ☐ Approved FMLA Approved Dates: __________________
☐ Denied Reason: __________________________________

Human Resources Director Signature: _______________________ Date: _______________

2/01/2014