Revised 1.26.2021

Print form

UNIVERSITY OF GEORGIA

Shared Sick Leave Program – REQUEST FORM Effective January 1, 2021

Clear Form

Employee Name: _____ Employee ID: _____

UGA email: _____ Preferred Telephone #: _____

Employee home mailing address: _____
Street, City, State and Zip Code

Department: _____

I am requesting Shared Leave under the terms specified in the Shared Sick Leave Program policy. I hereby acknowledge and certify the following:

- I am an active member of the Shared Sick Leave Program.
- I have enclosed a completed physician's certification of a serious health condition for myself or an immediate family member.
- I agree that I will notify the Office of Human Resources if I am approved for other benefits (i.e., Workers' Compensation, Short or Long Term Disability, Social Security Insurance, Disability Retirement, etc.) prior to or after I begin receiving donated sick leave.
- I acknowledge that I have read and understand the program provisions as set forth in the Shared Sick Leave Program policy.
- I understand that documentation of having a Power of Attorney is required with this form if I am acting on behalf of the employee recipient.

_____ _____

Absence Start Date Estimated return to work date

_____ _____

Signature of recipient (or authorized representative) Date

INSTRUCTIONS: Please complete and return this Shared Sick Leave Request form and the FMLA Medical Certification to the below address:

UGA Human Resources
Attn: Shared Sick Leave
Program 215 S. Jackson Street
Athens, GA 30602