VOLUNTARY SHARED LEAVE POLICY
SUMMARY OF MAJOR PROVISIONS

The intent of the Voluntary Shared Leave Policy is to allow one employee to assist another in case of a prolonged medical condition that results in exhaustion of all earned leave.

Participant Eligibility	The employee applying for shared leave must be full-time or part-time (assigned to 20 hours or more per work week) with a regular, probationary, trainee or time-limited appointment.
Definition of Prolonged Illness	A prolonged illness continues for at least 20 consecutive workdays and is documented by a medical professional.
Application Process	The employee may apply to participate in the shared leave program or be nominated for participation by a fellow employee.
Required Applicant/Nominee Documentation	• Applicant/Nominee Request for Vacation/PTO and/or Sick/Long Term Sick Leave • Authorization for Release of Medical and Other Information
Required Donor Documentation	• Donor of Vacation/PTO or Sick/Long Term Sick Leave Form
Donor Provisions	• Minimum donation is 4 hours. • Maximum donation amount of vacation/PTO leave by one individual cannot exceed the donor's total annual accrual. • The amount donated cannot reduce the donor's vacation/PTO leave balance below 1/2 of the annual accrual amount or Sick/Long Term Sick Leave Bank balance below 40 hours. • A minimum of 1 (one) employee must donate time in order for the recipient to be eligible to participate in the program. • Applicant is responsible for obtaining his/her own donors. • An immediate family member of any agency may donate Vacation, Sick, PTO or Long Term Sick Leave Bank time to another immediate family member in any agency (refer to Human Resources Policy Manual for definition of Immediate Family Member). • An employee may donate Vacation, Sick, PTO or Long Term Sick Leave Bank time (see Human Resources Policy Manual). • Holiday leave cannot be donated. • All donor forms must be received by Human Resources within 30 days of the employee's last work day.
Impact on Retirement Service Credit	For every hour of sick/Long Term Sick leave donated to Voluntary Shared Leave, there is a reduction in your retirement service credit. For additional information on the policy go to http://www.unchcsbenefits.com.
Confidentiality	The Privacy Act makes medical information confidential. When disclosing information on an approved recipient, only a statement that the recipient (or family member) has a prolonged medical condition needs to be made.

UNC HEALTH CARE

Human Resources

APPLICANT/NOMINEE REQUEST FOR VACATION/PTO AND/OR SICK/LONG TERM SICK LEAVE

Application for Voluntary Shared Leave Program

INSTRUCTIONS: This form should be completed within 30 days of the employee last work day by the employee requesting shared leave or by the nominating employee requesting leave on behalf of a colleague. Submit the completed form with the Authorization for Release of Medical and Other Information form and at least one donor form to:

UNC Health Care Employee Benefits
James T. Hedrick Bldg.
211 Friday Center Drive, Suite 1069
Chapel Hill, NC 27517

Shared Leave Recipient Name (Applicant or Nominee)	**Name**			
Applicant/Nominee's Employing Agency	**UNC Health Care**		**Other**	**Agency**
Applicant EID and Home Telephone Number	**EID**		**Home Telephone Number**	
Nominator's Name and Relationship (if applicable)	**Name**		**Relationship**	
Shared Leave Requested For	**Applicant's Medical Condition**			
	Immediate Family Member's Medical Condition			
Applicant's Dept. Name and Number	**Name**		**Number**	
TACS Coordinator Name and Phone Number	**Name**		**Phone Number**	
Applicant/Nominee's Last Work Day	**Date**	**Amount of Time Requested**	**Hours**	
Applicant/ Nominee or Nominator Signature	**Signature**		**Date**	

FOR HUMAN RESOURCES USE ONLY					
Appt. Type	**Type**	**Hours/Week**	**Hours**		
Waiting Period Begins	**Date**	**Waiting Period Ends**			**Date**
Date Leave Balances Checked	**Date**	**Sick/Long Term Sick Leave Bank**	**Hours**	**Vacation PTO**	**Hours**
Leave Balance Accrual Rates Per Pay Period		**Vacation/PTO**	**Sick/Long Term Sick Leave Bank**		
Medical Release Physician Statement Received	**Yes/No**	**Approved**	**Check**	**Denied**	**Check**
Human Resources Authorization					**Date**

Revised: 2.9.15

Human Resources

AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION

Application for Voluntary Shared Leave Program

I hereby authorize the physician, hospital, employer, agency or other organization to disclose to my employer any medical records or other information about my illness or illness of an immediate family member for which Voluntary Shared Leave has been applied. I understand that a copy of this authorization is considered to be as valid as the original. Questions may be e-mailed to Employee Benefits at benefits@unch.unc.edu.

Name of Shared Leave Program Applicant or Nominee	**Name**	
Applicant/Nominee EID	**EID**	
Name of Immediate Family Member (if applicable)	**Name**	
Immediate Family Member EID (if applicable)	**EID**	
Applicant, Nominee or Nominator Signature	**Signature**	**Date**
Applicant Address	**Street Address**	
	City, State, ZIP	

PHYSICIAN'S USE ONLY

The above named individual has applied/been nominated for UNC Health Care Shared Leave program. A physician's statement must accompany the Shared Leave Application. UNC Health Care will not assume responsibility for payment of fees associated with providing the requested information.

NOTE: This form must contain the physician's original signature. A stamp will not be accepted and may delay the Shared Leave application process. After completion of the form, please sign, date and return the form to the following address:

UNC Health Care Employee Benefits
James T. Hedrick Bldg.
211 Friday Center Drive, Suite 1069
Chapel Hill, NC 27517

PHYSICIAN'S DIAGNOSIS			
ESTIMATED DURATION OF ILLNESS OR CONDITION	**From**	**To**	**Current Date**
PHYSICIAN CERTIFICATION	**Signature**	**Printed Name**	
ADDRESS AND PHONE	**Street Address**		
	City, State, Zip		**Phone**

Human Resources

DONOR OF TRADITIONAL / PTO LEAVE

Application for Voluntary Shared Leave Program

INSTRUCTIONS: This form should be completed by the employee donating leave time to an applicant or nominee for the Shared Leave Program. All donations must be submitted within 30 days of the employee last work day. Donations are considered confidential unless the donor gives permission for this information to be released. Members participating in the Teachers' and State Employees' Retirement System will NOT receive credit at retirement for donated sick leave hours. Supervisors/Managers should collect donor forms and mail them to the following address:

UNC Health Care Employee Benefits
James T. Hedrick Bldg.
211 Friday Center Drive, Suite 1069
Chapel Hill, NC 27517

NOTE: Your donation cannot drop your leave balance below half of what you accrue per year. If your balance is already lower than that, you are not eligible to donate.

Shared Leave Recipient's Name	**Recipient's Name**			
Donor's Name and EID	**Donor's Name**		**Donor's EID**	
Donor's Relationship to Recipient	**Relationship**			
Donor's Dept. Name & Number	**Dept. Name**		**Dept. Number**	
Donor's Telephone Numbers	**Home Telephone**		**Work Telephone**	
Total Hours Donated	**Vacation/PTO Leave**		**Sick/Long Term Sick Leave Bank**	
Is applicant aware of your donation?	**YES**		**NO**	
Shared Leave Recipient Employer	**UNC Health Care**		**OTHER**	
If Other, State Agency Name, Address, Phone Number and Contact Person for Shared Leave	**Agency Name**			
Street Address	**City, State, Zip**			
Contact Name	**Phone Number**			
Donor's Signature and Date	**Signature**		**Date**	

FOR HUMAN RESOURCES USE ONLY					
Appointment Type	**Type**		**Hours Per Week**		**Hours**
Date Leave Balances Checked	**Date**	**Sick/Long Term Sick Leave Bank**	**Hours**	**Vacation PTO**	**Hours**
Leave Balance Accrual Rates Per Pay Period	**Vacation/PTO**		**Sick/Long Term Sick Leave Bank**		
Human Resources Authorization					**Date**

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