

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	<ul style="list-style-type: none"> • Applicant/Nominee Request for Vacation/PTO and/or Sick/Long Term Sick Leave • Authorization for Release of Medical and Other Information
Required Donor Documentation	<ul style="list-style-type: none"> • Donor of Vacation/PTO or Sick/Long Term Sick Leave Form
Donor Provisions	<ul style="list-style-type: none"> • 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 Voluntary Shared Leave Program Policy .
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.



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
 1025 Think Place, Suite 400
 Morrisville, NC 27560
 Or Fax 984-9741305

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	
Supervisor 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

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@unchealth.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
1025 Think Place, Suite 400
Morrisville, NC 27560
Or Fax 984-9741305

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



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
1025 Think Place, Suite 400
Morrisville, NC 27560
Or Fax 984-9741305

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