# Leave Sharing Recipient Application

**Employee Name: _____**
**Last First M.I.**

**Assignment Number: _____**

**Home Address: _____**

**Home Phone: _____ Work Phone: _____**

**Organization: _____**

**My identity ___ shall be revealed ___ shall not be revealed to potential donors.**

**EMPLOYEE'S CERTIFICATION:**
**I have provided the required medical certification. I shall not be required to reimburse donations unless one of the following situations occurs.**

1. **Compensation is received from another source for the same period of time I received leave sharing donations, such as when monies are received from the leave sharing program and subsequently workers' compensation benefits are received retroactively for that same period of time; or**
2. **University Human Resources determines that abuse has occurred. I shall be required to repay all donated hours, and/or may be subject to disciplinary action in accordance with the Standards of Conduct Policy.**
3. **Employees must be on approved Family Medical Leave (FMLA) to receive leave sharing donations.**

_____ _____
**Employee's Signature Date**

**SUPERVISOR'S APPROVAL:**
**I am aware that this employee is applying for participation in the leave sharing program.**

_____ _____
**Supervisor's Signature Date**