

**Abilene Christian University**  
**Application to Receive Leave from the Shared Leave Donation Bank**

Employee's Name

Banner ID #

Position/Department

Number of Shared Leave Bank Hours Requested

Applying for:

\_\_\_ Self                      \_\_\_ Relative                      Relationship to employee \_\_\_\_\_

**IMPORTANT: Attach supporting documentation from health care provider** to include medical information about the health condition, the date the condition commenced, the probable duration of the condition and the employee's ability to perform the essential functions of his/her job.

Description of catastrophic health condition:

Name, address & phone number of health care provider:

Date health condition began:                      Date employee anticipates being able to return:

Date permissible leave balances were exhausted or are anticipated to become exhausted:

This is to certify that I have read and agree to abide by Policy # 314-A of the ACU Employee Handbook, entitled Shared Leave Donation Bank.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

***To be Completed by the University***

Request has been                      \_\_\_ Approved for \_\_\_ shared leave donation bank hours

   \_\_\_ Denied because: \_\_\_\_\_

By \_\_\_\_\_  
Employee's supervisor

\_\_\_\_\_  
Date

By \_\_\_\_\_  
Director of Human Resources

\_\_\_\_\_  
Date

Forwarded to Payroll on \_\_\_\_\_ (date)