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 anticipate 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 #314.1 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)