Request for Leave Share **Certification of Health Care Provider for Immediate Family Member's Serious Health Condition**	**DHRM Policy 4.35, Leave Share**

Leave Share provides an employee who has exhausted available leave balances with the opportunity to receive and use donated leave from colleagues. Employees must submit a complete and sufficient medical certification of a serious medical condition or injury that prohibits the employee's ability to perform their job duties with or without reasonable accommodation. Return the completed form to your Agency's Office of Human Resources.

SECTION I – EMPLOYEE INFORMATION

Employee Name	
Employee Job Title	
Employee's Normal Work Schedule	
Dependent Child, Parent or Spouse's Name	

Description of the Care Needed for Dependent Child, Parent or Spouse as defined by Policy 4.35:

SECTION II – COMPLETED BY FAMILY MEMBER'S TREATING HEALTH CARE PROVIDER

Health Care Provider's Name	
Business Address	
Business Phone Number	
Business FAX or Email	
Type of Practice/Specialty	
Identify Serious Medical Condition for which leave is requested	
Approximate date the condition started or will start	
Provide your best estimate of time needed for caretaking responsibilities that requires the employee's absence from work	
Is the period of incapacity continuous or intermittent episodes?	
Provide your best estimate of how often and how long the intermittent episodes of incapacity will last.	
Treating Health Provider's Signature	**Date**

Employee Attestation

By my signature below, I attest that this is a true and accurate statement of my caretaking responsibilities for my immediate family member's medical condition and request for leave share donations. My failure to use donated leave in accordance with Policy 4.35 may result in formal disciplinary actions as outlined in DHRM Policy 1.60, Standards of Conduct.

Employee Signature	**Date**