LYNDEN SCHOOL DISTRICT (LSD)

SHARED LEAVE REQUEST / HEALTH CARE PROVIDER STATEMENT

LYNDEN SCHOOL DISTRICT EMPLOYEE - COMPLETE THIS SECTION

Employee Name (Last)	(First)	(MI)

Employee Job Title	Preferred Email	Building

Is this condition the result of an on-the-job injury? ☐ Yes ☐ No | Home or Cell Phone

Are you requesting shared leave to care for a family or household member? ☐ Yes ☐ No If yes, please provide:

Family/Household Member's Name:____Family/Household Member's Relationship:____________________

Name of Treating Health Care Provider	Health Care Provider's Phone

I hereby authorize the above-named health care provider to complete this form and disclose to the Lynden School District and its authorized representatives the diagnosis, treatment and anticipated duration of relevant conditions

I certify that I do meet the criteria. Specifically, my signature on this form certifies that:

- The conditions for which I seek shared leave have caused or is likely to cause me to go on leave without pay or to terminate my employment with the District if I do not receive shared leave;
- I have/will exhaust all applicable vacation and/or sick leave and all other forms of paid leave;
- I am not eligible for time loss compensation from Labor & Industries (RCW 51.32);
- I have not requested shared leave for this same illness this school year;
- I accrue and am eligible to use sick leave and/or annual vacation leave;
- I have abided by the District's policies regarding use of sick leave; and
- I have read and understand District Leave Sharing Policy 5406/5406P;

☐ I have emailed a statement to payroll authorizing LSD to release by district email to solicit staff members to donate such leave. At a minimum, the statement includes my name, position, building, approximate total number of hours requested and reason (general or specific) for request.

By signing this page, I acknowledge that I have read and agree to the terms described above.

Check one: ☐ I am the employee requesting shared leave, OR

☐ I am the household member of the LSD employee requesting shared leave, OR

☐ I am the family member of the LSD employee requesting shared leave

For family member, enter relationship to LSD employee______________________________

____

Signature Date

The State of Washington's Shared Leave Program is intended to allow employees to assist each other with leave donations to help cope with severe, extreme and/or life threatening health crises. Donated leave is intended to help employees in these circumstances to bridge unexpected absences that they do not have paid leave to cover and which would cause them to go on leave without pay for a period of time.

Examples of "extraordinary or severe" situations that are typically approved include:
Major surgery with inpatient hospital stay; outpatient surgery for severe condition; cancer and treatment; hospitalization for a severe physical or mental condition; enrollment in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work; bed rest due to high risk pregnancy-related complications.

Conditions that are typically not approved include:
Flu; chicken pox; pregnancy/delivery; sprained ankle; elective cosmetic surgery; intermittent leave for chronic, ongoing medical conditions.
Washington State Leave Sharing Program (see RCW §41.04.665 and 28A.400.380 and Chapter 392-126 WAC)

Request: Approved ☐ Denied ☐ ____ ____________________

Signature of Superintendent or Representative Date

Lynden School District Employee Name (Last) (First)

HEALTH CARE PROVIDER - COMPLETE THIS SECTION

Your patient is asking you to disclose information about him/her so that the Lynden School District can process a request to receive leave donations from other employees. The qualification criteria to receive shared leave are explained on page 1 of this form. The information you provide will be used to determine whether the medical condition meets the criteria for receiving shared leave.

Please complete this form and return both pages as directed at the bottom of this page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EVALUATION SUMMARY

Patient Name: Last First

Relationship to employee:

Pertinent Diagnosis(es) (name and description of condition)	Date condition commenced or diagnosed (mm/dd/yyyy)	Condition expected to last until (mm/dd/yyyy)	Please describe how this diagnosis meets the definition of a severe, extreme or life threatening illness or injury or pregnancy disability

Provide additional information regarding your diagnosis by checking all of the following that apply:	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
☐ Major surgery with inpatient hospital stay		
☐ Outpatient surgery for a severe condition		
☐ Hospitalization for severe physical or mental condition		
☐ Enrollment in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work		
☐ Bed rest due to high risk pregnancy-related complications (mother and/or fetal endangerment)		
☐ Treatment for condition described above (e.g., chemotherapy, dialysis, radiation etc.)		
☐ For LSD Employees: Patient will need to be on leave from work		

Notes:

HEALTH CARE PROVIDER INFORMATION

Health Care Provider Name (please print or type)

Provider's Specialty:

Health Care Provider's Address: Street City State ZIP

Health Care Provider Signature Date

Email:

Phone:

Return the completed form to the Lynden School District Payroll Office

(To Employee: DO NOT RETURN THIS FORM TO YOUR SUPERVISOR)

Lynden School District
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