



## LEAVE SHARING ASSISTANCE REQUEST FORM

Employee Name: \_\_\_\_\_

Date: \_\_\_\_\_

Employee's ID Number: \_\_\_\_\_

Employee's Supervisor: \_\_\_\_\_

I wish to request donated time from the Leave Sharing Assistance Program. I understand that it is not a guarantee that I will receive donated time and that I can receive no more than 6 weeks of donated time (30 days) over the duration of this program.

My request is due to experiencing one of the following situations:

- I have been unable to work remotely, thus missing hours and wages due to the COVID-19 virus.
- I have self-quarantined due to exposure to the COVID-19 virus.
- I have been diagnosed by a health care provider as having the COVID-19 virus.
- I have a need to stay home with children while schools are closed during the shelter in place ordinance.

With my signature below, I understand that:

- I have at least 3 months of MBI service in a full-time position.
- This request will remain in effect during the entire scope of this Program and end on December 31, 2020.
- I have exhausted all of my accumulated annual sick, personal, and vacation time, and I am currently unable to work due to the COVID-19 virus.
- The donated time that I receive will be considered wages, and I will be taxed accordingly.

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

Date: \_\_\_\_\_

Human Resources Approval: \_\_\_\_\_