

Voluntary Shared Leave Application

Employee Information

Name of Recipient _____ Position/Title _____
Employee ID _____ Supervisor _____
Division/Section _____ Supervisor Phone _____

Leave requested for Employee or Immediate Family (state relationship)

General Medical Condition (Attach Physician Statement)

Leave Balances

Vacation _____ Sick _____ Bonus _____

Employee Authorization

I, _____ have requested, or have been nominated, to receive leave under the provisions of the voluntary shared leave policy of the State of North Carolina and hereby authorize the disclosure of my need for donated leave.

Recipient Signature _____ Date: _____

Human Resource Staff Only

Amount of Leave Received

Vacation _____ Sick _____ Bonus _____

Amount of Leave Returned

Vacation _____ Sick _____ Bonus _____

____ Approved
____ Not Approved

Signature _____ Date _____

Date Donation Period Closed _____