



North Carolina Department of Public Safety

Voluntary Shared Leave Program Application/Release Form

SECTION 1: TO BE COMPLETED BY EMPLOYEE. Please print or type. Unsigned/un-dated forms will not be accepted. Please fax completed form (pages 1 & 2) to 919-582-6134 or submit to work unit HR Rep/Designee for forwarding to Central HR.

Applicant's Name: _____ BEACON #: _____

Work Location As It Will Appear On Broadcast: _____ Location Phone#: _____

Work Location
Contact: _____ Supervisor: _____

VSL Requested for: Employee Immediate Family Member Relationship: _____

Would you like your Voluntary Shared Leave participation broadcast in the Department? Yes No

Description of Medical Condition:

NOTE: The Medical Certification attached to this application must be completed or a doctor's statement containing the necessary information must be attached before the application will be considered.

I, _____, request participation in the Shared Leave Program due to the above mentioned medical condition. I hereby authorize the release of the above mentioned information for the purpose of receiving leave as prescribed by the Voluntary Shared Leave Program policy. I further authorize my treating physician to release any information acquired in the course of my examination(s) or treatment(s) to my employer as indicated for purposes of receiving donated leave in accordance with the Voluntary Shared Leave Program policy.

I understand that I may not force or coerce any individual into donating leave. The donation of leave under this program shall be entirely voluntary. If the use of force or coercion is discovered, it will be viewed as unacceptable personal conduct and dealt with accordingly.

Applicant's Signature Date

Management/Work Location Designee's Approval Signature **(REQUIRED)** Date

SECTION 2: TO BE COMPLETED BY DPS CENTRAL VSL COORDINATOR ONLY:

Approved Denied Reason for Denial: _____

Central HR VSL Coordinator's Signature Date

Last Day Worked: _____ LOA Date: _____ Leave Exhaustion Date: _____

Donation Period: From _____ To _____ FML designated: YES NO Applied for STD: YES NO

Balance as of: _____ VL: _____ SL: _____ BV: _____ Comp: _____

Leave Received: _____ Leave Used: _____ Leave Returned: _____



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SECTION 3: PHYSICIAN CERTIFICATION: Please have the treating physician complete this Section. Fax completed physician certification along with application/release form to 919-582-6134 or submit to facility HBR for forwarding to Central HR.

I hereby certify that I first treated _____
(Give name of patient)

for his/her present disability on _____
(Month) (Day) (Year)

and that he/she became disabled to perform his/her regular job on _____
(Month) (Day) (Year)

with a diagnosis of _____

and that he/she is/was continuously disabled to the extent that he/she could not perform his/her regular job duties from that date through _____.
(Month) (Day) (Year) (Need estimated date.)

Please list any symptoms or medications related to the condition that may interfere with the employee's ability to perform his/her regular job duties: _____

The prognosis is that the total length of his/her disability will be approximately _____ weeks.

If the patient is not the employee/applicant, please furnish a detailed statement describing the medical care that the employee/applicant will be providing: _____

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) (29CFR 165.8(b)(1)(i)(B)) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, please do 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 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 embryo lawfully held by an individual or family member receiving reproductive services. Please do not send office visit notes as they may contain medical information not relevant to the request for accommodation.

Physician's Name (Print) _____ Signature _____ Degree _____ Date _____

Physicians Suppliers and/or Group Name _____ Telephone Number _____