I. RECIPIENT REQUEST and ACKNOWLEDGEMENT

Employee Name ____

Title ____ Dept. _________________________

Describe nature of medical condition below and attach physician's statement (required):

Projected Duration ____

Anticipated Return-to-Work Date ____

__________ (Initial) If approved, I wish to have my Shared Leave Request distributed to all departments.

I hereby acknowledge that I have read and understand Macon County's *Voluntary Shared Leave Policy,* dated November 2012, and request voluntary shared leave in accordance with the policy.

Employee Signature ____________________________________ Date ___________________

II. AUTHORIZATION

☐ Approved

☐ Disapproved

Additional Comments

County Manager's Signature _________________________________

Date___________________