APPLICATION FORM FOR PARTICIPATION IN THE ROCKINGHAM COUNTY VOLUNTARY SHARED LEAVE PROGRAM

DATE:______________________________

TO: HUMAN RESOURCES

Name:_____________________________________

Department:______________________________________

Job Title:____

Description of Medical Condition:____

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Estimated Length of Time Needed to Participate in Program:________________________

____

____ I elect my shared leave request to be communicated to my department only.

____ I elect my shared leave request to be communicated county-wide.

For Official Use Only

Comp-Time Leave Balance _____ Sick Leave Balance _____

Vacation Leave Balance ______

Reviewed/Recommended by HR: _________________________ Date_______________

☐ APPROVED

☐ DISAPPROVED

By:____, County Manager

Date:__________________________

RELEASE FORM – RECIPIENT
ROCKINGHAM COUNTY VOLUNTARY SHARED LEAVE PROGRAM

DATE:________________________

TO: PERSONNEL DEPARTMENT

I, ____, hereby authorize the release of my medical status and my vacation and sick leave status for the purpose of my participation as a recipient of the Rockingham County Voluntary Shared Leave Program.

____
Signature of Employee