**AR 7540**

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**WAYNE COUNTY PUBLIC SCHOOLS**

**VOLUNTARY SHARED LEAVE**

**APPLICATION FOR PARTICIPATION**

Employee's Name:

Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Work Site:

Position:

Medical Condition requiring the need for additional leave:

Estimated amount of time needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the Wayne County Board of Education Voluntary Shared Leave Committee to make known through system-wide communications my need for additional leave. Only general information about my condition/or immediate family member’s condition is to be released beyond the Committee.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Applicant Date

NOTE: Statement from Medical Doctor Must Be Mailed Directly to:

 Human Resource Services

 Wayne County Public Schools

 P. O. Drawer l797

 Goldsboro, NC 27533-1797

Approval:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chairman, VSL Committee Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Superintendent or Designee Date

**Note:** Participation in this program is on a voluntary basis. The donating employee may not receive compensation in any form for the donation of leave. Any employee found guilty of giving or receiving compensation may be subject to dismissal as outlined in G.S. 115C-325. (Board Policy 7540)