COUNTY OF SAMPSON
VOLUNTARY SHARED LEAVE
APPLICATION FOR PARTICIPATION

Employee Name: _____

Last 4 Digits of SS#: ___ ___ ___ ___ Employee ID#: ___ ___ ___ ___

Department: _____

Position : _____

Medical Condition requiring the need for additional leave:

_____

_____

Estimated amount of time needed: _____

I authorize the Sampson County Voluntary Shared Leave Committee to make known through system-wide communications my need for additional leave. Only general information about my condition is to be released beyond the committee.

_____ _____
Employee Signature Date

NOTE: Statement from medical doctor MUST be sent directly to:
Patty Jackson, Human Resources Benefits Specialist
pjackson@sampsonnc.com

Approval: _____ _____
Department Head Date

_____ _____
Chair of Voluntary Shared Leave Committee Date

_____ _____
County Manager Date