

SHARED VACATION APPLICATION

THIS PROGRAM APPLIES ONLY TO EMPLOYEE

Name: _____

Social Security # _____

Work Location _____

Hours worked per day _____

Absent from _____ to _____ for a total of _____ hours.

I am member of the Sick Leave Bank and received _____ hours.

Member of the Sick Leave Bank YES _____ NO _____

Reason for request

I have requested a medical verification form from my physician certifying I am unable to perform the duties of my job due to serious and/or extended medical condition.

I have received and read a copy of the Memorandum of Understanding covering this program.

Print Name _____

Sign Name _____

Fill out this form in its entirety and return to:

Salem-Keizer Association of Classified Employees
PO Box 17038
Salem, OR 97305