University of Alaska
Leave Share Program
Temporary Disability Leave Transfer Request

MAU/Major Administrative Unit (circle one) UAA UAF UAS SW	Department
Last Name First M.	
Employee ID	Work Phone

FOR RECIPIENT USE ONLY

Please complete and forward to your personnel office

Medical reason for absence(attach physician's statement): _____

_____

Date all paid leave will be exhausted: _____

Date expected to return to work: _____
(Must be more than 10 working days after exhaustion of paid leave)

I am not receiving compensation under Workers' Compensation, Long Term Disability or from any other compensation. I am currently eligible to use Temporary Disability Leave (per University Regulation 04.06.G.13.b). I understand that any hours used will be included in my gross income as compensation.

Recipient Signature: _____ Date: _____

Personnel: _____ Date: _____

Payroll: _____ Date: _____

REGIONAL PAYROLL USE ONLY

Total hours received must not exceed 65 days (520 hours) per calendar year. Part-time employee will participate according to their prorated proportion of full-time (per University Regulation 04.06.G.13.b.).

Donor ID	PP END	Hours	TOTAL

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ORIGINAL: Regional Payroll COPY: Regional Personnel, Recipient

Form B350 (7/04)