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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