

**CHARLOTTE-MECKLENBURG SCHOOLS
APPLICATION FOR VOLUNTARY SHARED LEAVE**

Please Print:

Employee's Name (Recipient): _____ Employee Number: _____

Position: _____ Work Location: _____

Estimated Amount of time needed: _____

A request for leave form must be submitted before you an application for voluntary shared leave will be reviewed.

*If you are/become eligible for short term disability donated leave may only be used during the 60 day waiting period.

I understand that my name and only general information (no specifics) concerning my need for additional leave may be release. I understand that any employee found guilty of giving or receiving compensation for shared leave may be subject to dismissal as outlined in G.S. 115C-352.

Signature of Employee

Date

*Submit to:
CMS Benefits
Fax: 980-343-3996
Courier: 846*

Benefits Use Only:

Approved: _____

Signature of Benefits Coordinator