



COLUMBUS STATE
UNIVERSITY

**Shared Leave Program
Recipient Affidavit
Shared Leave Request Form**

I request a leave award from the Shared Leave Program under the terms specified in the University's Program description, and with the understanding that the specific nature of my illness will be kept confidential.

Name of Recipient (Print) _____ Employee ID # _____

Department _____ Phone # _____

Date Medical Condition Began _____

Date Medical Condition Ended (or is expected to end) _____

I am submitting herewith medical verification which confirms a life-threatening or emergency medical condition as described in the Columbus State University Shared Leave Program policy.

I certify that the above statements are true and complete to the best of my knowledge.

Signature of Recipient or Authorized Recipient Representative

Date _____

INSTRUCTIONS: Please forward this Recipient Affidavit and supporting documentation to Human Resources. Mark "confidential" and c/o the "Shared Leave Certification Committee".