LENOIR COMMUNITY COLLEGE

SHARED LEAVE PROGRAM APPLICATION

Name:	
Employee ID Number:	
Position:	
Estimated Length of Disability:	
Description of Medical Condition: (Attach supporting documentation)	

I request permission to participate in the Shared Leave Program and am willing to have my disability or medical condition made known to other LCC employees. I understand that such disclosure could result in the release of confidential information.

_____ _____

Signature **Date**

_____ _____

Tasha Johnson **Date**
Director of Human Resources

□ **Approval** □ **Disapproval**

8/15/17