

**Montgomery County
Leave Sharing Request**

To Be Completed by Employee Requesting Donated Leave:

Name: _____ Date: _____

Department: _____ Employee ID #: _____

From: _____ To: _____

Reason for Request:

- MEDICAL:** For personal illness or injury that is not job-related or for pregnancy-related condition.

- FAMILY:** For birth or adoption of a child; for placement of foster child; to care for a seriously ill spouse child or parent.

Employee Signature: _____ Date: _____

Employee's Manager: _____ Date: _____

To Be Completed by Human Resources

Accrued Sick Leave Hours* _____

Accrued Annual Leave Hours* _____

Human Resources Signature: _____ Date: _____

* Must be equal to zero as of effective date leave share would begin.