

**GONZAGA UNIVERSITY**

**SHARED VACATION LEAVE PROGRAM APPLICATION FORM**

Name: \_\_\_\_\_ S.S. # or Employee ID #: \_\_\_\_\_

Department: \_\_\_\_\_ Your Position: \_\_\_\_\_

Please explain nature of leave:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date leave began: \_\_\_\_\_

Anticipated Dates of UNPAID LEAVE PERIOD:

From: \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Benefits Office Signature

\_\_\_\_\_  
Date

NOTE: ATTACH CERTIFICATION OF HEALTH CARE PROVIDER FORM

