

**State of Oklahoma—Office of Personnel Management  
Request for Shared Leave**

**Part 1. To be completed by employee requesting shared leave**

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Employee Name	Social Security Number	Job Code
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Agency Name	Agency #	Work Location
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I request donated leave as authorized by Title 74, Section 840-2.23 of the Oklahoma Statutes. I certify that I am eligible for and require family leave; or I am suffering from, or my relative or household member is suffering from, an extraordinary or severe illness, injury, impairment, or physical or mental condition which has caused or is likely to cause me to take leave without pay or terminate employment and I have exhausted or will exhaust all annual and sick leave; or I have recently experienced the death of a relative or household member; or I have been affected by a presidentially-declared national disaster in Oklahoma which resulted in injury, death, or destruction of property as specified in the law. I have not received the maximum of 365 days of shared leave allowed for a terminal illness or the maximum of 261 days allowed for other conditions during total state employment. **A medical certificate from a licensed physical or health care provider verifying the severe or extraordinary nature and expected duration of the condition is attached, as required (if applicable).**

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Signature of Employee	Date
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**Optional:** I request that my name (first name, last initial, and employing agency) be placed on the OPM "Shared Leave Registry" which is located on the OPM Website ([www.opm.ok.gov](http://www.opm.ok.gov)). Placement of my name on the Registry indicates that I: (1) need shared leave, and (2) am eligible to receive shared leave. I understand that donation of shared leave between employees in different state entities requires the agreement of the appointing authorities (or authorized designees) of those entities. I also understand that my name will be posted on the OPM Website for a two-week period. (Posting for an additional period will require completion of a new OPM-33.) I further understand that this information will be available for review by anyone having internet access, including individuals outside of state government, and accept complete responsibility for this request.

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Signature of Employee (If requesting to be listed on OPM's Shared Leave Registry)	Date
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Agency Contact Name and Title	Phone #	E-mail
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**Part 2. To be completed by agency of employee requesting shared leave**

Receiving employee's leave balance:

Annual \_\_\_\_\_ hours as of \_\_\_\_\_ Sick \_\_\_\_\_ hours as of \_\_\_\_\_ Hourly rate of pay \_\_\_\_\_

Previous shared leave used \_\_\_\_\_ (number of days)

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Signature of Agency Verifying Official	Date
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\_\_\_\_\_ Approved      Agency policy \_\_\_\_\_ does \_\_\_\_\_ does not (check one) allow shared leave to be accepted from employees of another state agency.

Approval includes authorization to list on the OPM Website, if requested by the employee.

\_\_\_\_\_ Disapproved      **(After approval/disapproval, provide a copy to requesting employee)**

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Signature of Appointing Authority	Date
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**Note:** Following approval by employee's Appointing Authority, fax this document to OPM at (405) 522-1752, if posting on the OPM Website is requested.