

**SHARED SICK LEAVE BANK EMPLOYEE REQUEST FORM**

**Employee Section**

Employee name: Click here to enter text. Today’s date: Click here to enter text.

Employee ID: Click here to enter text.

Position: Click here to enter text. Department: Click here to enter text.

I request distribution of sick leave hours from the Shared Sick Bank due to my disability as a result of serious illness/injury causing an absence from work in excess of my available accrued leave hours as defined in the Shared Sick Leave Policy 5.37. I am requesting shared sick leave from \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_.

Please check:

I am employed full-time.

I will/have exhausted all my accrued paid leave as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

FMLA will coincide with use of shared sick leave.

I acknowledge the shared sick leave limit is 160 hours.

To the best of my knowledge I understand that this request requires appropriate medical certification and will be reviewed and approved and/or denied according to policy.

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

Employee Signature/Date

**Human Resources Section**

Request for shared sick leave received on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date

According to policy 5.37.1 the employee must meet the following qualifications:

1. Employed full-time for at least 12 months.

Yes  No Date of Full Time Hire:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Absent from work at least 15 continuous working days.

Yes  No

Date of absence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Exhausted all accrued paid leave.

Yes, as of \_\_\_\_\_\_\_\_\_\_\_\_\_  No

1. HR has received certification from licensed medical provider.

Yes, Certification received on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No

Date

1. Employee must have completed a minimum of 1 year of continuous full time employment since the conclusion of the most recent use of shared sick leave.

Yes  No  N/A

Employee meets criteria for shared sick leave as outlined in Board Policy.

Yes  No

Human Resources Director Signature/Date

**Approving Officials**

Approve  Denied Approve  Denied

Vice President Signature/Date President Signature/Date