

OSEA Sick Leave Bank Request for Withdrawal

Name: _____ Date: _____

Address: _____

School or Department: _____ Phone: _____

Number of days requested: _____ Anticipated Date of Return: _____

1. I have used:
 - a. All individual accumulated paid sick leave.
 - b. All paid individual personal leave
2. I have attached the following to this request form:
 - a. Personal statement indicating the circumstances for which I am requesting this additional sick leave.
 - b. Physician Statement indicating that I am unable to perform my assigned responsibilities due to a long-term illness or injury.
3. I authorize the Sick Leave committee to verify my date of employment, paid sick leave balances and paid personal leave balances.
4. I understand that any unused sick leave days will be returned to the Sick Leave Bank.
5. I affirm that the information I have provided is accurate to the best of my knowledge.

SIGNATURE: _____ DATE: _____

For committee use Only

Date Request received: _____ Date Request reviewed: _____

REQUEST APPROVED: _____ REQUEST DENIED: _____

If denied, state reason: _____

Number of days granted: _____ Beginning on: _____

Number of days unused and returned to the Sick Leave Bank: _____

Signature of Committee Chair: _____