

SICK LEAVE BANK REQUEST - LICENSED

Name _____
(please print)

Phone _____

School or Department _____

Number of days requested _____ Anticipated date of return _____

1. I have used:
 - a. All my individual accumulated sick leave
 - b. All my 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's 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 this 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 _____