# REQUEST FOR SICK LEAVE CONVERSION

Employee Name: ______________________ Employee ID #: ____________ HRS/Day: ______

Work Site/Department: ______________ Position: ______________ Phone #: ______________

☐ CERTIFICATED (VUTA) ☐ CERTIFICATED MANAGEMENT ☐ CLASSIFIED (CSEA) ☐ CLASSIFIED MANAGEMENT

**I am requesting participation in the Sick Leave Conversion Program for:**

**Name of Family Member :** ______________________

**Relationship to Employee:**

☐ Spouse ☐ Child ☐ Parent ☐ Domestic Partner ☐ Grandparent ☐ Grandchild ☐ Sibling

☐ Designated Person **Relationship to employee:** ______________________

**DATES OF LEAVE:** ______________ **TO** ______________ **INTERMITTENT LEAVE** ☐ YES ☐ NO

## A Certification of Health Care Provider Form or equivalent medical certification is required.

This request is accompanied by a written verification signed and dated by the treating physician certifying that the illness or injury is one that incapacitates a member of your family and requires you to take time off from work to care for that family member. The written verification must include the family members name, the incapacitating nature of the illness/injury, and anticipated duration of the leave.

Signature: ______________________ Date: ______________

## FOR HRD USE ONLY

☐ Approved ☐ Denied

Comments:

______________________________________________

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Approved/Denied By: ______________________ Date: ______________

**Return Form to: Human Resources-Employee Benefits**
**5000 W Cypress Ave, Visalia CA 93277**