Request for Extended Sick Leave

Employees that have a catastrophic injury or illness for themselves or an immediate family member OR maternity leave for new mothers may request 25 days of extended sick leave that must be used consecutively.

This is after all state and local leave have been exhausted.

This leave is offered at a prorated rate of $85.00 per day, and will be payroll deducte

Once exhausted, the rate will increase to your current daily rate of pay.

This leave can only be requested one time per employee per school year.

Procedures for requesting extended leave

1. Submit completed form with a doctor's note / attending physician's Statement to the Business Office.

2. You will be notified via email If approved and the 25 days of extended leave will be placed in your leave bank and can be seen in the Employee Payroll Portal Module.

Request for Extended Sick Leave Days

Please complete this form and return to the Business Office. An official **Extended Sick Leave Request and also an Attending Physician's Statement** must also be submitted before this request can be considered. Extended Sick leave days shall be used for a catastrophic illness or injury of the employee or immediate family member or maternity leave for new mothers. Leave must be used consecutively.

Date: _____/_____/_____

Employee Name: _____

Address: _____

Telephone: _____ Campus/Dept. _____

Patient's name if different than above: _____ Relationship to employee: _____

I have or will have used all my available state and local leave, as well as any compensatory time and vacation days, as applicable.

I am requesting leave: Begin: _____/_____/_____ End: _____/_____/_____

Nature of illness or injury*:

_____

_____

_____

Date illness began or accident occurred: _____/_____/_____ Date physician consulted: _____/_____/_____

Name, address, and phone number of attending physician:

_____

_____

_____

Did the condition require hospitalization? Yes _____ No _____

If yes, please complete the following information:

Name of hospital: _____

Dates of confinement: Begin: _____/_____/_____ End: _____/_____/_____

I certify that the information given on this request for extended sick leave days is accurate and true.

Signature of Employee: _____Date: _____

*** GINA NONDISCLOSURE NOTICE:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

For Business Office Use Only

Date Received: _____

Date Employee Enrolled in Catastrophic Extended Leave: _____

Date Decision Communicated to Employee: _____ Granted _____ Denied _____