

REQUEST FOR SICK LEAVE BANK DAYS

Please complete this form and return to the business office. An official **Sick Leave Bank Attending Physician's Statement** must also be submitted before this request can be considered. Sick leave bank days shall be used only for the catastrophic illness or injury of the employee or member of the employees immediate family.

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 sick leave bank 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 HR Department Use Only

Date Received: _____

Date Employee Enrolled in Catastrophic Leave Bank: _____

Date Decision Communicated to Employee: _____ Granted _____ Denied _____

