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UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

HUMAN RESOURCES

SICK LEAVE BANK REQUEST FORM

FOR EMPLOYEES NOT COVERED BY A COLLECTIVE BARGAINING AGREEMENT WITH THE EXCEPTION OF SHARE AND NAGE EMPLOYEES

Employee Name _____ ID# _____

Address _____ Home Phone _____

Job Title _____ Department _____

Supervisor _____ Extension _____

Requested SLB Time: From _____ To _____ Total Hours __

Nature of Illness or Injury: _____

I am applying for time to be granted to me from the Sick Leave Bank. Attached is the **Medical Certification** from my physician and my **Family and Medical Leave Application**. I have read the policy governing the Sick Leave Bank and understand that:

1. Additional documentation and/or medical consultation may be requested by the Sick Leave Bank Committee at any time during my sick leave. My Department Head/Supervisor will be consulted for a review of my past attendance record**.**

2. I may not draw on the Sick Leave Bank while also receiving income from Worker's Compensation and/or an employer sponsored disability insurance plan.

3. All accrued vacation, personal, sick and holiday compensatory time must be used and I must be absent without pay for five days or a pro-rata amount for a regular part-time employee before eligible to draw time.

4. All vacation and sick time which is accrued for any month during which I am using time from the Sick Leave Bank will be reassigned to the Sick Leave Bank.

5. The decision of the Committee is binding and is not subject to any campus or grievance appeal procedure.

Employee's Signature _____ Date _____

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Distribution: SLB Committee, File, Employee