

# CERTIFIED SICK LEAVE BANK REQUEST FORM

Please print all responses.

Date: \_\_\_\_\_

Name of Requestor: \_\_\_\_\_

Has all sick leave, personal leave and discretionary leave been exhausted?

Yes\_\_\_ No \_\_\_

If no, what date will your paid leave expire? \_\_\_\_\_

Have you submitted a Family Medical Leave request to the Human Resources Department?

Yes\_\_\_ No\_\_\_

What is the anticipated start and end date for your absence? I plan to be off from work:

\_\_\_\_\_ through \_\_\_\_\_  
(Start date) (End date)

How many days are you requesting? \_\_\_\_\_

Reason for request: (attach separate page, if needed)

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## HIPAA Privacy Authorization

*Your privacy is important to us and we are committed to protecting your personal health information. Please answer the following question to authorize the sharing of this document with members of the Certified Sick Leave Bank committee.*

The information disclosed in this request may be shared with members of the Certified Sick Leave Bank Committee.

Yes\_\_\_ No\_\_\_

Employee Signature: \_\_\_\_\_