



Shared Sick Leave Request Form

Employee Name:	Banner ID No.:
Department:	Contact Phone Number:
Number of Hours Requested:	Email address:
Reason for Request (Attach appropriate documentation from medical provider including description of injury or illness, date of onset or initial diagnosis, prognosis and anticipated date of return to duty):	

I certify that I have read the College's Shared Sick Leave Program Policy and understand my rights as outlined in the policy. I agree to abide by the procedures and conditions outlined in the policy. I understand that I must submit this form with the required medical documentation before this request can be considered.

Employee's Signature

Date

**Request Form must be submitted to
Human Resources – Attention: Shared Leave Pool Manager
in an envelope or via email marked "Confidential."**

Shared Leave Pool Committee Action		
Approved:	Denied:	If approved, number of hours granted:
If denied, reason for denial:		
Shared Leave Pool Manager Signature:	Effective Date of Action:	