# Dcclogo Shared Sick Leave Request Form

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| **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.”**

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| **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:** | |

Form AD-007/001 (1/2021)