# DcclogoShared 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:** |

Form AD-007/001 (1/2021)