Stephens College

Sick Leave Share Request Form

Instructions: Please complete the information below and submit to Human Resources.

Employee Statement:

This is to request participation in the Sick Leave Share Program. I have a medical condition as specified in the attached physician's statement that is resulting in my absence from work. I certify that I am not receiving Long-term Disability income or Workers' Compensation benefits.

____ I have exhausted all of my vacation and sick leave hours.

____ I authorize Human Resources to release information indicating that I have a catastrophic medical condition which would otherwise be confidential personnel record information and that I desire Sick Leave Share donations.

____ I have attached current medical statement (dated within 30 days) from a licensed medical care provider verifying the need for leave and the expected duration of the condition which I will provide each month.

____ I understand that the amount of Sick Leave I am awarded will count as time against the Family Medical Leave Act.

Requestor's Information:

Employee Name: Phone Number:

Employee Signature: Date:

Employee Department:

Amount of Hours Requested:

Hours Granted:

Human Resources Signature: Date: