Transylvania University
Sick Leave Bank Request Application

Date of Application: ____

Last Name: ________________ First Name: __________________________

Home Address: ____

Home Phone: _________________

Department & Position Title: ____

Name of Supervisor: ____

Have you previously used the Sick Leave Bank (SLB)? ☐ Yes ☐ No

If yes, what were the date(s) of prior use? ___________________________

Does the condition qualify under the FMLA? ☐ Yes ☐ No

Date of first absence related to this condition: __________________________

Are you receiving any of the following compensable benefits?

- Workers' Compensation ☐ Yes ☐ No
- Disability ☐ Yes ☐ No

Date all leave was or will be exhausted: ____________________________

Number of SLB days requested: _______

I have submitted a Medical Certification Form confirming the serious health condition as defined under the FMLA. I understand that the maximum number of days that may be withdrawn is thirty (30) days per event and/or year.

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any falsification, I will not be considered for Sick Leave Bank benefits and that I may be removed from the Sick Leave Bank.

Any exceptions to qualifications can be reviewed and approved by HR and the SET subcommittee on a case by case basis.

_____________________________________ _________________________

Signature of Employee or Legal Representative Date

SICK LEAVE BANK DETERMINATION

(To be completed by Sick Leave Bank Administrator)

Request Approved: ☐ Yes ☐ No Date: ____________________

Number of Days (hours) Approved: ____________

Effective Date: ___________________ End Date: ___________________ Date

Returned to Work: _____________________

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Signature of Sick Leave Bank Administrator