Western Illinois University
HUMAN RESOURCES

**SICK BANK LEAVE REQUEST FORM**

ONLY EMPLOYEES WHO HAVE DONATED TO THE BANK ARE ELIGIBLE TO REQUEST SICK LEAVE FROM THE POOL.

*Name*______________________________ *WIU ID No.*____________________

*Rank/Title*______________________________ *Percent Appointment*____________________

*Department*______________________________ *Office Phone*____________________

*Campus Address*________________________________________________________

An employee who is a member of the Voluntary Sick Leave Bank may request sick leave (maximum of twenty working days) from the pool after exhausting accumulated leave. Leave may be requested and used only for catastrophic personal illness or injury of the employee or to care for a parent, spouse, domestic partner, or child with a serious health condition as stipulated under the Family and Medical Leave Act (FMLA). A licensed medical practitioner's statement describing the severity of the illness or injury, the diagnosis, the date it began, and probable duration must be included with this request.

I hereby request approval of the following Sick Leave Bank usage:

Number of Days Requested ____________ Beginning Date of Leave ____________

Reason for Request ________________________________________________________

________________________________________________________________________

*Name of person experiencing catastrophic illness or injury* and *relationship to the employee* ________________

**A licensed medical practitioner's statement describing the severity of the illness or injury, diagnosis, the date it began, and probable duration is attached**.

______________________________ ______________________________

*Signature of person making request* *Date*
*(If requestor is other than the employee, please indicate relationship to the employee)*

*TO BE COMPLETED BY THE SICK LEAVE BANK COMMITTEE*

*Date Received*____________________ *Membership Verified*____________________
*Cumulative Leave Balance*____________________ *Number of Days Approved*____________________
*Non-cumulative Leave Balance*____________________ *Number of Days Used*____________________
*Awarded Bank Days Used*____________________ *Days Reverting to Bank pool*____________________
*in the past 12 months*

( ) *Request Approved* ( ) *Request Denied*

______________________________
*Authorized Committee Signature*

**For completion by a LICENSED MEDICAL PRACTITIONER**

Answer, full and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

Severity of the illness or injury:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Diagnosis:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Date it began:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Probable duration:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

________________________________________ __________________________
Signature of Licensed Medical Practitioner Date

Practitioner's name and business address: ____________________________________________

Type of practice / Medical specialty: _________________________________________________

Telephone: _______________________________ Fax: __________________________