REQUEST FOR ADVANCED SICK LEAVE FORM

Name: _____

Position: _____

Date employee will exhaust their Sick Leave: _____

Number of days of Advanced Sick Leave requested: _____ (Maximum of 15 days)

Scheduled return to work date: _____ (Must be within the period of time covered by the Advanced Sick Leave Request)

Reason for request:

I understand that:

- Upon return to work, all of my earned Sick Leave will be applied to the leave deficit at the rate of 1¼ days per month (or if part-time, the monthly earning rate) until the deficit has been eliminated.
- If I separate from State employment before satisfying the leave deficit and return to State employment at a later date, the leave deficit will need to be satisfied upon reemployment.

Employee's Signature/Date: _____

Supervisor's Signature/Date: _____

Department Head/Program Manager Signature/Date: _____

State Human Resources Officer Approval/Date: _____

NOTE: Attach documentation from a health care provider stating that the employee is expected to return to work within the period of time covered by the Advanced Sick Leave Request