

CONFIDENTIAL
LONG-TERM DISABILITY LEAVE BANK REQUEST FORM

NAME _____

BUILDING _____

HOMEADDRESS _____

HOME PHONE _____ SCHOOL PHONE _____

HAVE YOU CONTRIBUTED TIME TO THE LEAVE BANK SYSTEM? _____

BRIEFLY DESCRIBE THE NATURE OF YOUR DISABILITY OR ILLNESS AND
THE CIRCUMSTANCES THAT CAUSED YOU TO MAKE THIS REQUEST.

NUMBER OF LEAVE BANK DAYS REQUESTED _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? _____

HAVE YOU USED ALL OF YOUR ACCUMULATED SICK LEAVE? _____

COMMENTS: _____

EMPLOYEE SIGNATURE

Date

Committee Use Only

Date Considered _____ () Approved () Not Approved

Committee Chairperson

Number of Days Credited _____
*If not approved, chairperson will
inform applicant as to why.