MURRAY STATE UNIVERSITY
SICK LEAVE BANK MEMBER REQUEST FORM

Section I. Employee Information (Please Print)

Last Name_____ First_____ M.I._____ M #_____

Department_____ Position Title_____ Office Phone No._____

Home Phone No._____ Cell Phone No._____

My normal work day is ☐ 7.5 ☐ 8.0 ☐ other_____

Section II. Sick Leave Request (Maximum of 30 days per illness or injury)

I am a member of the Murray State University Sick Leave Bank, and I am requesting paid sick leave from the Murray State University Sick Leave Bank due to a catastrophic illness or injury. I have used (or will have used) all my accrued sick leave and vacation leave. I am requesting certification from a licensed medical practitioner stating the beginning date of the condition, a description of the catastrophic illness or injury, and the date I expect to return to work. I understand that monthly progress report will be required to extend sick leave benefits and this specific request can be for a maximum of **30 days only**.

I am requesting _____ days from the Sick Leave Bank to be credited to my sick leave balance.
(Maximum of 30 days per illness or injury)

(1) _____ _____
Employee or Responsible Party's Signature Date

(2) _____ _____
Department Head Signature Date

Section III. Authorization (To be completed by Human Resources)

Last day of work _____ Number of days approved per this request _____

Last day of paid leave _____ Total number of sick leave days previously approved _____

Number of sick leave days requested _____ Total number of sick leave days granted to date _____

Return to: **Human Resources**
412 Sparks Hall
Murray State University
Murray, KY 42071

FOR OFFICE USE ONLY

Sick Leave Bank Participant _____ Yes _____No
Approved _____ Denied _____
If approved,
Begin date _____
Thru EOD _____

Sent to Payroll_____
Sent to Employee _____
Sent to Department _____
Request PA from Department _____
Copy to Benefits File_____
Enter on H: Drive Spreadsheet

Human Resources Signature _____ Date _____