

SHARED BENEFITS PROGRAM
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

STAFF EMPLOYEE REQUEST FOR SICK LEAVE CREDIT

TO BE COMPLETED BY EMPLOYEE REQUESTING LEAVE

Name:		Date:
UIN:	Classification:	
Department	Phone:	
Department Address:	Phone:	
Home Address:	Phone:	
Departmental Contact Person to Be Notified of Change in Benefit Balance		
Name:		
Departmental Address	Phone:	
Have you donated at least one full day of accrued benefit leave to the pool?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you applied for Disability from SURS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Number of Sick Leave Days Requested:		days

TO BE COMPLETED BY THE PERSONNEL SERVICES OFFICE

Percent Time:	Number of Sick Leave Days Granted:	
Compensable Sick Leave Balance	Non-Compensable Sick Leave Balance:	Vacation Balance:
Request Approved <input type="checkbox"/>	Request Denied <input type="checkbox"/>	
Reason Denied:		

Attach a physician's statement indicating the beginning date of the illness or injury, a description of the condition and a prognosis for recovery. A request submitted without this statement will be returned to the employee.

Return this form with a physician's statement to:
Labor & Employee Relations
Personnel Services Office
52 East Gregory Drive
MC 562