NORTHEAST STATE
We're here to get you there

# NON-FACULTY SICK LEAVE BANK REQUEST

MEMBER NAME_____ ID #_____

MEMBER DEPARTMENT_____

DAYS REQUESTED: FROM____/____/____ TO____/____/____

REASON FOR REQUEST (attach a separate sheet if necessary)_____

_____

_____

_____

MEMBER'S SIGNATURE_____ DATE____/____/____

SUPERVISOR'S SIGNATURE_____ DATE____/____/____

**PLEASE NOTE: A CERTIFICATE OF CONDITION FROM A STATE-CERTIFIED PHYSICIAN MUST ACCOMPANY THIS FORM**

**SUBMIT ALL FORMS TO THE LEAVE ADMINISTRATOR**
**(Becky Bennett)**

**TO BE COMPLETED BY THE LEAVE ADMINSTRATOR**:

ACCRUED LEAVE BALANCES SICK_____ ANNUAL_____ COMP____

SIGNATURE_____ DATE____/____/____

**FORWARD TO BOARD OF TRUSTEES**

**TO BE COMPLETED BY TRUSTEES:**

APPROVED ____ NUMBER OF HOURS ____

DISAPPROVED ____ REASON_____

_____

CHAIRPERSON SIGNATURE_____DATE____/____/____

**ORIGINAL SENT TO PERSONNEL, CC TO LEAVE ADMINISTRATOR AND MEMBER, COPY TO NON-FACULTY SICK BANK CHAIRPERSON.**

# SICK BANK CERTIFICATE OF CONDITION

_____ is an employee at Northeast State Community College and is a member of the college's sick bank. The purpose of the sick bank is to provide emergency sick leave to members of the program who have suffered an unplanned personal illness, injury, disability, or quarantine and who have exhausted their personal compensatory, sick and annual leave. Sick bank time cannot be granted for elective surgery.

The employee listed above is member of the sick bank and has requested leave time from the sick bank. Sick bank regulations state that the employee must provide a certificate of condition from a state-certified physician verifying the nature of the illness or injury and the inability of the employee to work.

Please complete the section attached identifying the nature of the illness and/or extent of injury and certifying the condition to be a disability to perform the employee's regular assigned duties and the anticipated return to work date.

Employee's absence is due to an unplanned personal illness, injury or disability. (Elective procedures ineligible) YES ____ NO ____

Employee will be unable to work for approximately _____ days/weeks.

(Job Description attached)

## CERTIFICATE OF CONDITION

Nature of illness/extent of injury:

Anticipated return to work date:

I certify that the above illness/injury is a disability that will prevent the employee from performing his/her regular assigned duties.

State reason/reasons:

_____ _____

Physician's Signature Date

Physician's Printed Name _____

c: Sick Bank Administrator
Human Resources