University of Toledo/CWA Local 4530
Sick Leave Recipient Application

(Please Print)

Applicant's Name: (Last, First, Middle)	UT Claim #:
Current Address:	Social Security Number:
Department:	Home Telephone:
Department Location:	Office Telephone:
Position Title:	Date of Hire:
Date current catastrophic illness was diagnosed:	Date expected to return to work:

Name of physician who will verify the catastrophic illness: (Attach documentation from the physician, showing the diagnosis, prognosis, and duration of the illness.)

Name of individual completing this application (If applying on behalf of the applicant): _____	Relationship to Applicant:	Telephone Number:

Consent to Release Information:
I verify that the above information is true and I give permission to authorized Sick Leave Bank Committee members to review the attached physician's statement for the sole purpose of determining whether to grant or deny my application for sick leave from the sick leave bank

(Signature of applicant or applicant's representative):

_____

Privacy Act Statement:
Participation in this program is voluntary; however, solicitation of this information is authorized by P.L. 100-566 (October 31, 1988). The information furnished will be used to identify records properly associated with the application to become a leave recipient. It may also be disclosed to a national, state, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, or regulation, or to another agency or court when the Government is party to a suit. Executive Order 9398 (November 22, 1943) authorized use of the Social Security Number (SSN). Furnishing the Social Security Number as well as other data, is voluntary, but failure to do so may delay or prevent action to this application.

Payroll Office Verification:	How many hours of leave without pay have been used for this catastrophic illness? _____	What is the applicant's leave balance as of the end of the last play period? Sick_____ Vacation_____ Comp Time_____

Personnel department medical documentation is: ☐ Satisfactory ☐ Unsatisfactory

Signature: Date:

Leave bank board's official decision, signature, and date signed: ☐ Approve ☐ Disapprove

Signature: Date: