University of Toledo/PSA
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:

The nature of illness or injury must be certified by a licensed physician as "catastrophic" within the meaning of Section IV, B of the PSA Sick Leave Bank Policy. Attach Certification of Health Care Provider form to this application.

Name of Licensed, Attending Physician:_____

Date current catastrophic illness or injury was diagnosed:	Date expected to return to work:
What is the applicant's leave balance as of the end of the last pay period? Sick _____ Vacation _____ Comp Time _____	How many hours of leave without pay have been used for this catastrophic illness or injury?

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

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.

Consent to Release Information:
I certify that the above statements are true and I give permission to the authorized Sick Leave Bank Committee members to review this application for the sole purpose of determining whether to grant or deny my request for sick leave from the Sick Leave Bank.
Signature of applicant or individual applying on behalf of the applicant:

_____ Date Signed:_____

HR: Medical documentation is ☐ Satisfactory ☐ Unsatisfactory. Signature: Date:

SLB: Application for Sick Leave is ☐ Approved ☐ Disapproved. Signature: Date: