Morehead State University
Sick Leave Bank Request Application

Date of Application: _____ MSU ID #: _____
Last Name: _____First Name: _____Middle Initial: ____
Home Address: _____
Home Phone: _____
Department & Position Title: _____
Name of Supervisor: _____
Have you previously used the Sick Leave Bank (SLB)? ☐ Yes ☐ No
If yes, what were the date(s) of prior use? _____
Does the condition qualify under the FMLA? ☐ Yes ☐ No
Date of first absence related to this condition: _____
Are you receiving any of the following compensable benefits?

- Workers' Compensation ☐ Yes ☐ No
- Disability ☐ Yes ☐ No

Date all leave was or will be exhausted: _____
Number of SLB days requested: _____

I have submitted a Medical Certification Form confirming the serious health condition as defined under the FMLA and UAR 304. I understand that the maximum number of days that may be withdrawn is sixty (60) days in a rolling twelve month period.

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any falsification, I will not be considered for Sick Leave Bank benefits and that I may be removed from the Sick Leave Bank.

_____ _____
Signature of Employee or Legal Representative Date

SICK LEAVE BANK DETERMINATION

(To be completed by Sick Leave Bank Administrator)

Request Approved: ☐ Yes ☐ No Date: _____

Number of Days (hours) Approved: _____

Effective Date: _____ End Date: _____

Date Returned to Work: _____

_____
Signature of Sick Leave Bank Administrator