NOTE: No more than 30 leave credits may be withdrawn at a time.

COMMITTEE FOR PUBLIC COUNSEL SERVICES

SICK LEAVE BANK WITHDRAWAL REQUEST

Name: _____ Date of Hire: _____/_____/_____

Div./Unit: _____

I request a withdrawal of _____ leave credits from the Sick Leave Bank to be applied toward my approved unpaid leave of absence for the period of _____/_____/____ through _____/_____/_____. I have attached a completed Leave of Absence form, signed by my supervisor, and the required certification by the attendant practitioner of my prolonged illness.

To assist us in determining your eligibility for, and in coordinating, the withdrawal of leave credits from the Sick Leave Bank, please respond to the following questions:

1. Are you eligible to receive compensation from a state-sponsored or private long-term disability plan, or any other source of compensation? ☐ Yes ☐ No If yes, indicate the following:

   Type of compensation: _____ Is there a waiting period for receipt of compensation? ☐ Yes ☐ No
   Length of waiting period: _____ workdays

   Effective dates of compensation: _____/_____/_____ through _____/_____/_____.

   (Note: An employee who is covered by LTD may request withdrawal(s) from the Sick Leave Bank for the associated "waiting period" only, provided that s/he has exhausted all earned leave credits.)

2. Is your prolonged illness work related? ☐ Yes ☐ No If yes, has it been reported to CPCS? ☐ Yes ☐ No

I certify that the information provided on this request form and any other information furnished by me is true and correct to the best of my knowledge. I confirm that I am not currently receiving compensation from a state-sponsored or private long-term disability plan, or any other source of compensation.

I have read the CPCS Sick Leave Bank policy and understand that requests for additional withdrawals may be subject to review and further certification by the attendant practitioner of my prolonged illness. In accordance with the CPCS Leaves of Absence policy, changes in the approved leave of absence period must be communicated to my supervisor and to the Human Resources Unit.

Signature: _____ Date: _____

DIVISION/UNIT SUPERVISOR ACKNOWLEDGEMENT:

Signature: _____ Date: _____

HUMAN RESOURCES UNIT ELIGIBILITY CERTIFICATION AND RECOMMENDATION:

I certify that the aforementioned employee:

☐ does meet the eligibility requirements of the Sick Leave Bank policy.
☐ does not meet the eligibility requirements of the Sick Leave Bank policy for the following reason(s):
_____

I recommend that the employee receive _____ leave credits from the Sick Leave Bank for payment during the period of _____/____/_____ through _____/_____/_____.

_____ _____
Signature of Director of Human Resource Management Date

CHIEF COUNSEL APPROVAL/DISAPPROVAL:

☐ I approve the employee's request for withdrawal of leave credits from the Sick Leave Bank:

☐ as recommended by the Human Resources Unit
☐ as modified herein: _____
_____

☐ I disapprove the employee's request for withdrawal of leave credits from the Sick Leave Bank for the following reasons (s):
_____
_____

_____ _____
Signature of Chief Counsel or His/Her Designee Date

Revised 12/02