Emerson COLLEGE | Human Resources

Massachusetts & California Employees: Staff

Shared Sick Bank Program

Sick Time Request Form

Name		Date of Request	
Title		Employee ID #	
Department		Hire Date	
Requester Name (if other than employee)		Phone & Email	

Please indicate how many sick days you are requesting:

I am requesting (indicate number of days) ______ days of sick time for my own catastrophic illness or injury (maximum request: twenty (20) sick days annually).

Are you currently on an approved leave for your own medical condition or to care for an immediate family member? My Own Medical Condition Immediate Family Member

Please explain your circumstances. If it is for your own medical condition or to care for a family member:

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	Yes	No
If you work in Massachusetts and are on leave for your own medical condition, have you applied for short-term disability or Workers' Compensation?		
If you work in California and are on leave for your own medical condition, have you applied for or are you receiving California Disability Insurance or Workers' Compensation?		
If you work in California and are on leave to care for an immediate family member with a medical condition, have you applied for or are you receiving California Paid Family Leave?		
Have you provided Human Resources with all documentation requested as part of the leave process?		

If not, please attach any additional required information.

Please explain:

Please provide any other information that you would like to be considered as part of this request:

Please check each of the following:

I understand that as part of the approval process my supervisor may be contacted to confirm that I am in good standing (not on a performance improvement plan.

I understand that as part of the approval process I may need to speak with a representative from e4health Employee Assistant Program, the 3rd party vendor with decision-making authority regarding my request about my situation and the reasons for my request.

I understand that as part of the approval process e4 EAP may need to speak with my healthcare provider, a social worker, a clergy person or others who may be familiar with my situation.

I understand that if this request is approved, payments are subject to all applicable taxes and will be processed through the College's regular payroll process.

I understand and acknowledge that my participation in the Program is strictly voluntary and that I have not been coerced, threatened, intimidated or financially induced to participate in the Program.

By signing below, I confirm that I have read and agree to the terms set forth in the Shared Sick Bank Program and have fully and truthfully answered the questions in this Shared Sick Bank Program Request Form.

Employee Signature　　　　　　　　Date

Requester Signature (if different from employee)　　　　Date

Please send your request to Human Resources

INTERNAL USE ONLY to be completed by HR Leave Administrator:

Leave of Absence Administrator Signature Date　　　　Receipt Date

Sent to EAP Vendor:

Completed by EAP Vendor:

Date decision returned to HR Leave Administrator:

Request for donated sick time approved: Yes　　　　No

Yes If yes, number of days allocated:

If the request is denied, state reasons:

Other Information:

HR Leave Administrator

Date requesting employee is notified:

Date sick time transferred to the employee:

Date supervisor is notified, if applicable for payroll purposes: