SHARED BENEFITS PROGRAM

UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

STAFF EMPLOYEE REQUEST FOR SICK LEAVE CREDIT

TO BE COMPLETED BY EMPLOYEE REQUESTING LEAVE	
Name:	Date:
UIN:	Classification:
Department	Phone:
Department Address:	Phone:
Home Address:	Phone:
Departmental Contact Person to Be Notified of Change in Benefit Balance	
Name:	
Departmental Address	Phone:
Have you donated at least one full day of accrued benefit leave to the pool? Yes ☐ No ☐	
Have you applied for Disability from SURS? Yes ☐ No ☐	
Number of Sick Leave Days Requested: ____ days	

TO BE COMPLETED BY THE STAFF HUMAN RESOURCES		
Percent Time:	Number of Sick Leave Days Granted:	
Compensable Sick Leave Balance	Non-Compensable Sick Leave Balance:	Vacation Balance:
Request Approved ☐ Request Denied ☐		
Reason Denied:		

Attach a physician's statement indicating the beginning date of the illness or injury, a description of the condition and a prognosis for recovery. A request submitted without this statement will be returned to the employee.

Return this form with a physician's statement to:
Labor & Employee Relations
Staff Human Resources
52 East Gregory Drive
MC 562