

SICK TIME PROGRAM APPLICATION FORM



Employee Name (Please Print): _____ Employee ID#: _____

Home Address: _____ City _____ ST _____ Zip _____ Home/Cell#: _____

Department Name: _____ Extension: _____

Supervisor: _____ Director: _____

Indicate the continuous dates of missed work that you are requesting PTO donations for:

Reason for request of Sick Time Program (must attach physician documentation):

Statement: I have exhausted all of my PTO hours and have been out for a prolonged period of time (15 consecutive days or more) due to an illness/injury or a catastrophic illness of a spouse, parent, son or daughter when the employee qualifies for Family Medical Leave. I have reviewed and understand the Sick Time Program policy located on the infoNET under Corporate Policies 4.02.03. I have attached a statement from the physician who treated the illness/injury that resulted in the use of my PTO hours, attesting to my continuing need to be absent from work. I further understand that this application will not be accepted without the physician statement attached.

Employee Signature: _____ Date: _____

Please scan application and physician documentation to SickTime.Program@uhs-sa.com.

FOR PROGRAM ADMINISTRATION ONLY:

Date application and physician documentation received in Human Resources: _____

Approved for dates: _____ through _____

Denied/Reason: _____

Extended until: _____

Program Administrator: _____ Date: _____