SICK TIME PROGRAM APPLICATION FORM

University Health System
Thinking beyond

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

Home Address: _____City _____ST_____Zip_____Home/Cell#:_____

Department Name:_____Extension: _____

Supervisor:_____Director:_____

Work Hours (Full Time/Part Time) (example: FT, 40 hrs): _____

Approximate Days/Hours Requested: _____

Reason for request of Sick Time Program: (Please attach physician justification):

_____

_____

_____

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.

Employee Signature: _____ Date: _____

Please scan application to selia.goddard@uhs-sa.com & brandie.gamboa@uhs-sa.com

FOR PROGRAM ADMINSTRATOR ONLY:

Date application received in Human Resources: _____

☐ Approved for dates: _____ through _____

☐ Denied ☐ Has not been out 15 days ☐ Not an illness/injury ☐ No paperwork from physician

Notes:_____

☐ Extended until:_____

Program Administrator:_____ Date:_____