EMPLOYEE SICK LEAVE BANK
Department of Human Resources – Employee Relations
910 Madison Avenue, Suite 764 | Memphis, TN 38163 | 901.448.5600

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Withdrawal Request Application

Employee Information

Name: _____
LAST FIRST MIDDLE

Personnel Number: _____ DOB: _____

Department and Position Title:_____

Home Address: _____City: _____ State: _____ Zip: _____

Email: _____ Phone: (_____)_____

Have you previously received sick leave from the Sick Leave Bank? ☐ Yes ☐ No

Name used during previous withdrawal, if different from present name: _____

Reason for Leave

1). My absence is due to: _____

_____

2). First day of absence due to this condition: _____

3). Date **ALL** leave days (sick, annual, compensatory time, personal day) exhausts: _____

4). Number of days requested: _____

5). List compensation from other sources (i.e., disability insurance, social security, retirement): _____

_____

Signature

I understand that leave grants from the bank shall not be more than 30 consecutive days per initial days for any one illness or accident. I have attached a physician's statement confirming the illness or injury.

_____ _____
Employee Signature or Legal Representative Date

RETURN FORM TO HUMAN RESOURCES

910 Madison Avenue, Suite 764
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Email: bmarti75@uthsc.edu