UNIVERSITY of MARYLAND BALTIMORE

Advanced Sick Leave Request Form

☐ **Original Request** ☐ **Extension**

PART I: To be completed by Employee

Name of Employee: _____Employee ID#: _____

Home Address: _____ City: _____ State: ____ Zip Code: _____

Dates of absence: _____ Days requested (up to 15 days per year of service not to exceed 60): _____

Current Department: _____ Job Title: _____

Supervisor's Name: _____ Payroll Representative's Name: _____

Requests for Advanced Sick Leave must be supported by medical certification by an accredited, licensed, or certified medical provider and must be submitted along with this request. The certification must include your name, physician's name, address, phone number and signature. It must also include the date the absence will begin and the probable or expected return to work date.

(Failure to complete the form in its entirety or provide medical verification may result in a delay in processing the request.)

I acknowledge and agree that any sick leave advanced to me is considered a debt and that upon my return to work I am required to repay the University by applying, at a minimum, one-half of my sick and annual leave earnings each pay period. I understand that, in addition to the minimum payback, I may elect to pay back the advanced sick leave debt by applying any earned leave or by reimbursing the University with cash. Any debt remaining at the time of my separation from the University may be taken out of my final wages and any leave owed to me at the time of my separation. Further, this debt is enforceable until repaid, even after my separation from University service whether voluntary or involuntary. I also understand that I may not be eligible for further advanced sick leave until this debt is repaid.

_____ _____

Employee's Signature **Date**

Part II: To be completed by Department or Payroll Representative

Date on which all earned leave (sick, annual, holiday, personal, or compensatory) will expire: _____

Number of days the employee has been absent from duty on sick leave (3-year period): _____2023 _____2024 _____2025

Has employee previously been granted Advanced Sick Leave? _____ If yes, the current balance is: _____

Is this a request for additional Advance Sick Leave for the same injury or illness? _____

Part III: To be completed and signed by Supervisor: _____ _____

Print **Signature**

Has employee:	**YES**	**NO**
Exhausted all types of accrued leave?		
Performed at a level of "meets standards" or better in the last 12 months?		
Been placed on sick note certification in the last 12 months?		
Been disciplined for absenteeism in the last 12 months?		

Part IV: To be Reviewed and Signed by Department Head

[] Approved [] Declined _____ _____ _____

Signature Print Name Date

To be Reviewed and Signed by Director of Human Resource Services or Designee

[] Approved [] Declined _____ _____ _____

Signature Print Name Date