Return To:
Office of Human Resources
1851 North Research Drive
Bowling Green, OH 43403
Fax: 419-372-2920

Print Form

Leave Bank Withdrawal Request

1. Employee's Name	2. BGSU ID Number
Last First M.I.	
3. Title	**4. Employee Type**
	◯ Classified ◯ Administrative ◯ Faculty

5. Department

Name

HR Department Code

6. Phone Number

Phone Type

7. Address to be contacted at

Address Type

I understand that I must be:

Initial ☐ An employee who is eligible to accrue and use sick leave, or an academic employee during an active (non grant funded) appointment period.

☐ I must be on an approved leave of absence for myself/family member.

☐ Suffering a serious injury or illness causing me/family member to be incapacitated.

☐ Provide a doctor's verification of illness or injury, which includes an estimated return to work date, to Human Resources, to be forwarded to the Leave Bank Committee.

☐ I must exhaust all paid leave (sick, vacation, personal and Compensatory Time Off) before I am eligible to receive the hours from the Leave Bank.

☐ I may not be on any other University pay status, receiving State disability benefits,or receiving Worker's Compensation benefits and will notify Human Resources of any change to my pay status.

☐ Participation is subject to the provisions as outlined in the Leave Bank Policy.

☐ I have made donations to the leave bank in one of the two most recent enrollment periods.

Please review policy 3341-5-18 for additional information and clarification

Continue to other side ⇨

- COMPLETED BY Office of Human Resources-

Requestor's Employment Status	Total Leave Hours Requested	Requestor's Rate of Pay	Requestor's Leave Bank ID
◯ Full time ◯ Part Time FMLA ◯ Y ◯ N			
Signature of LB Representative/Designee	Funding ◯ General Fund ◯ Auxiliary		Date
Request Received on:	Credit Date for Requested Leave	Signature of LB Record Keeper	

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_____
Date Received

I, _____ hereby request the use of _____ hours * of leave from the Leave Bank, for a serious illness or injury to myself or qualified family member (see policy). I have attached form LB- 1003 *Certification of Physician* and have notified my immediate supervisor. The purpose of my leave meets the conditions of the *Leave Bank Policy*.

* Not to be less than 80 hours and not to exceed 240 hours

A. Serious illness or injury- time away from work due to a serious non-worker's compensation health condition which incapacitates the employee or requires care and assistance for a family member with a documented medical condition, that is life threatening or requires a lengthy convalescence.

Serious illness/injury involves:

1. A period of incapacitation or treatment when an employee cannot do her/his job and does not have the ability to perform normal activities due to serious illness/injury and is connected with with inpatient care (e.g. an overnight stay) in a hospital, hospice, or residential medical care facility; or
2. A prolonged absence requiring ten or more consecutive working days, and that also involves continuing treatment by (or under the supervision of) a licensed health care provider; or
3. A period of incapacity due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc.); or
4. A period of incapacity that is long-term due to a condition for which treatment may be ineffective (e.g., stroke, terminal disease, etc.); or
5. An absence to receive multiple treatments or testing requiring a period of recovery, (e.g. restorative surgery or after an accident or other injury, or for a chronic condition such as cancer or kidney disease).

A period of incapacity refers to a situation where the employee/family member can not do her/his job and does not have the ability to perform normal activities in her/his daily life or engage in normal recreational activities.

Convalescence refers to a gradual returning to health/recovery/recuperation after illness or incapacity, or gradual healing (through rest) after sickness or injury.

_____
Signed By Date

- COMPLETED BY Office of Human Resources -

Checklist		
	☐ Leave Request Form Signed and Completed	☐ Certification of Physicians Form LB-1003 Attached; or
	☐ Leave Bank Membership Verified	☐ Certification of Physicians Form LB-1004 Attached
	☐ A Workers Compensation Claim Has Not Been Filed	☐ Requestor Has or is About to Exhaust all Paid Time Off ↳ Date Time was exhausted or predicted date _____