APPENDIX D
Attachment C

WESTERN OREGON UNIVERSITY

Donated Leave Bank

REQUEST FOR BENEFIT FORM

Employee Name: ______________________________ Date of Request: ________________

Department: ___________________________ Position: _____________________________

Hire Date: ____________________________ Phone Number_________________________

I hereby request ______ hours of sick leave benefits from the Donated Leave Bank for the following reason (check one):

__ l. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. *(Employee must submit the University's Physician Certification Form within 15 calendar days from the date of request.)*

__2. To care for an immediate family member because said family member has a serious health condition.

Circle one: CHILD –PARTNER/SPOUSE – PARENT – OTHER

____________________ __________________________________
Date Employee Signature