

**Hilliard Education Association**  
**Sick Leave Need Request Form**

Employee Name: \_\_\_\_\_

School Building: \_\_\_\_\_

Employee Home/Cell Phone Number: \_\_\_\_\_

Employee Work Email: \_\_\_\_\_

According to the Sick Leave Transfer Policy, a member may request days under one of the following reasons. Please check which number your request meets.

\_\_\_\_ 1. Hospitalization or catastrophic illness as defined by the treating physician of the B.U.M.

\_\_\_\_ 2. Hospitalization or catastrophic illness as defined by treating physician of B.U.M.'s immediate family.

\_\_\_\_ 3. Medical leave for pregnancy shall be limited to a maximum of 15 days with a regular delivery or up to 20 days for Cesarean birth.

**Sick leave transfer days may not be used to extend maternity leave past the normal six or eight week period of time. Sick leave requests for post maternity leave may only be transferred for extreme circumstances as stated in #1 and #2 above.**

What is your expected date of leave, or pregnancy due date? \_\_\_\_\_

What is your expected return to work date? \_\_\_\_\_

4. Please provide a brief description of your catastrophic illness. \_\_\_\_\_

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As outlined in Article XXVII, Section A. 1. m. of the Master Agreement between the Hilliard Education Association and the Hilliard Board of Education, I understand that I must exhaust all of my accumulated sick leave and personal days before any days will be transferred to me.

**A doctor's statement is attached to this form.**

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Sick Leave Chairperson Signature: \_\_\_\_\_

Date: \_\_\_\_\_