

**Request for Use
of the
State of Illinois Employee Sick Leave Bank**

Instructions: Employees shall keep a completed copy and retain copies of all attachments for their records. A physician's statement is required and should be submitted with the completed form to the agency's sick leave bank coordinator / personnel office. The agency will then forward all necessary information to CMS Labor Relations.

Name XXX-XX- ____ ____ ____
Social Security Number
(Last four digits)

Agency Title Bargaining Unit

Agency Address Work Phone

Home Address Home Phone

Employee explanation of nature of catastrophic illness or injury. You may use an attached sheet. Also, attach the physician's medical statement (similar to or utilize CMS 95).

Number of Sick Days Requested _____ (25 day maximum)

By my signature, I declare that I am currently an active Sick Leave Bank member, will have used all available benefit time by _____, and am eligible to request use of the Sick Leave Bank.

Employee Signature Date