**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.**

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**Name Social Security Number**

**(Last four digits)**

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**Agency Title Bargaining Unit**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Agency Address Work Phone**

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**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).**

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**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.**

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**Employee Signature Date**

**IL 401-1531 (rev 8/2014)**