STATE OF TENNESSEE
EMPLOYEE SICK LEAVE BANK
SEVENTEENTH FLOOR, TENNESSEE
TOWER 312 ROSA L. PARKS AVENUE
NASHVILLE, TENNESSEE 37243-0635
TEL. (615) 741-5431 FAX (615) 532-3209

WITHDRAWAL REQUEST APPLICATION

Please complete and submit this to your HR representative to upload in Edison. The Sick Leave Bank must receive this application no earlier than two weeks prior to the expiration of all accumulated sick, compensatory, and annual leave, but no later than thirty (30) workdays after the expiration of all accumulated leave.

Is your absence due to your own personal health condition? Yes_____ No_____

Is your absence due to the care of a biological, adopted, foster child, stepchild, legal ward or child for whom you are standing in place of an absent parent, who is under age 18? Yes_____ No_____

Employee's Name: Last _____ First _____ Home Phone # (_____)_____

Employee's ID Number: _____ DOB: _____ _____ _____

Preferred E-mail Address: _____

Home Address: _____ City _____ State _____ Zip _____

Employee's Department and Position Title: _____

Have you previously received sick leave from the Sick Leave Bank? ..... Yes ____ No ____

Name used during previous withdrawal if different from present name: _____

1) My absence is due to _____
   My first day absent due to this condition was _____
2) Did you enroll within the last 2 years? Yes ____ No ____ If yes, provide the names and telephone numbers of all the physicians from which you received treatment or advice for this illness/injury/medical condition: _____
   _____
3) Is your current illness/injury/medical condition work-related:
   A. From state employment?..... Yes ____ No _____
   B. From other employment or service connected? Yes ____ No ____ If yes, indicate employer/branch of service:
      Employer/Branch of Service Name: _____ Date of Incident: _____
   C. Have you filed a Worker's Compensation claim with the Division of Claims or another employer? Yes ____ No ____
4) Have you applied for Social Security disability? Yes ____ No ____ Date applied: _____
5) Are you currently approved for or receiving Social Security disability? Yes ____ No ____ If yes, effective date: .._____
6) Have you applied for retirement through the Tennessee Consolidated Retirement System? ..... Yes ____ No _____
7) Are you currently earning and/or receiving income from other employment? (excluding pensions).....Yes ____ No _____
8) Have you applied for State Short- or Long-Term Disability insurance benefits? Yes____ No____ Date Applied: _____
9) Are you currently approved for or receiving State Short or Long Term Disability Insurance benefits? Yes_____ No_____
   If yes, effective date: _____

I provided my medical doctor/surgeon with a Medical Certification form to confirm my illness or injury as required by the Sick Leave Bank ("SLB") Guidelines. I instructed my medical doctor/surgeon to send the completed form directly to the SLB at the address listed at the top of the form. I further authorize the Sick Leave Bank to share this information with my agency's leave administrator(s) in order to make a determination of eligibility for any other type of protected leave. I understand that leave grants from the SLB shall not exceed more than thirty (30) consecutive days per application. I understand that the maximum number of days a member receives for an accident, illness, or an illness related to, resulting from, or recurring from a previously diagnosed illness is ninety (90) days. In addition, leave grants shall not exceed ninety (90) days within a twelve (12)-month period as defined in the guidelines.

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should any investigation show any material misrepresentation of facts, I will not be considered for SLB benefits. The SLB Board of Trustees may remove me from the SLB, and I may be subject to disciplinary action up to and including dismissal. Additionally, in the event my eligibility for similar benefits changes (i.e., Social Security Disability, etc.), I must provide written notice no later than 10 calendar days after the eligibility date for said similar benefits absent extraordinary circumstances. I am aware that if I am approved of said other benefits; SLB may be forced to recoup any overlapping grants paid through SLB. I hereby authorize the SLB to make all necessary investigations concerning this application. I further authorize and request any records or information, including but not limited to medical, Workers' Compensation, service connected disability, State Retirement, Social Security disability, or Short or Long Term Disability Insurance that is sought in connection with this application be provided to SLB.

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Signature of Employee or Legal Representative and Date

Determination of initial applications made within ten (10) workdays from receipt of all necessary documentation.