SHORT-TERM DISABILITY
LEAVE REQUEST FORM

Employee Name _____ Employee Number _____ Date _____

I am requesting Short-Term Disability (STD) for the dates below. I am charging the first three days of absence to Paid Time Off (PTO) or Leave Without Pay. If applicable, I have attached medical documentation showing my length of absence. Below I am requesting the PTO that needs to be charged, or showing the dates that I have already been charged PTO, showing I am eligible to charge STD.

I am requesting STD for:

- ☐ Injury/Illness lasting more than three days: I am charging a total of 24 PTO hours
- ☐ Sick Family: I am charging 24 PTO hours related to this relative and condition
- ☐ Birth/Adoption of a child: I am charging a total of 24 PTO hours for this event
- ☐ Ongoing Injury/Illness occurring within the last thirty days from the last related absence and I have charged a total of 24 PTO hours
- ☐ Chronic Condition and I have charged a total of 24 hours related to this condition
- ☐ Dates that I have already been charged related to this absence

_____ _____

☐ PTO Leave Dates — Time Begin/Time End

Or ☐ Leave Without Pay

_____

Total Time Requested – PTO/Leave Without Pay

_____ _____

STD Leave Dates — Time Begin/Time End

_____

Total Time Requested – STD

_____ _____

Department Director's Signature — Date