

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 (Unless I am currently at the maximum number of STD hours (1,250) then all I am not required to charge the first three days to PTO)*. If applicable, I have attached medical documentation showing my length of absence. Below I am requesting the PTO or STD that needs to be charged, or showing the dates that I have already been charged PTO, proving 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
- I have 1250 hours of STD and not required to charge the first three days to PTO*
- 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
Or Leave Without Pay

Time Begin/Time End

Total Time Requested – PTO/Leave Without Pay

STD Leave Dates

Time Begin/Time End

Total Time Requested – STD

Department Director's Signature

Date