KANSAS CITY, KANSAS HOUSING AUTHORITY
EMPLOYEE SICK LEAVE BANK

Administrative Offices
1124 North 9th Street
Kansas City, KS 66101
Tel. (913) 281-3300 Fax (913) 279-3428

WITHDRAWAL REQUEST APPLICATION

Please complete and submit this withdrawal request application form through your personnel office. This application must be submitted no later than five (5) working days after all accrued sick leave time has been exhausted.

Employee Social Security Number _____

Name of Employee _____ Home Phone # _____
Last First Middle

Department & Position Title _____

Have you previously used the Sick Leave Bank? Yes ____ No ____ If yes, what was the date(s) and reason(s) of prior use? _____

Name used during previous withdrawal if different than present name _____

1) My absence is due to _____
My first day of absence due to this condition was _____

2) Is this a work-related injury or illness? Yes _____ No _____

3) Are you currently receiving or approved for Social Security disability? Yes _____ No _____ Effective Date _____
If no, have you applied for Social Security disability? Yes _____ No _____ Date Applied _____

4) Are you currently working at other employment? Yes _____ No _____

5) Date <u>all</u> leave expired (sick, compensatory, annual) _____

6) Number of days requested _____

I have attached a Medical Certification Form or a Supplementary Documentation for Continuing Disability Form confirming the illness or injury as required by the rules of the Sick Leave Bank. I understand that leave grants from the bank shall not be more than one-fourth of the balance in the Bank at the time of the request or a maximum of twenty (20) working days, whichever is less, and that the maximum number of days that may be withdrawn in one calendar year is twenty (20) working days. Also, it is understood that if I return to work before any granted hours have been expended, the hours are returned to the sick leave bank.

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should an investigation show any falsification, I will not be considered for Sick Bank benefits, that I may be removed from the Sick Leave Bank, and may be subject to disciplinary action up to and including dismissal. I hereby authorize the Sick Leave Bank 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, or Social Security disability, that is sought in connection with this application to be provided to the Sick Leave Bank.

_____ _____
Signature of Employee or Legal Representative Date

<u>MUST BE SUBMITTED WITH MEDICAL CERTIFICATION FORM OR CONTINUING DISABILITY FORM</u>

<u>SICK LEAVE BANK DETERMINATION FORM</u>
(To be completed by Sick Leave Bank Coordinator)

Request Approved: Yes _____ No _____ Emp ID # _____ Date _____

Number of Days Approved _____ Effective Date(s): _____

_____
Signature of Sick Leave Bank Coordinator

Form F-200 (01/03)