

Employee Name, ID, and FTE: _____

Department: _____ Title: _____ Date of Hire: _____

Contact Information (Email/Phone): _____

Onset of illness/disability: _____ Date current leave exhausts: _____

Projected return date: _____ Number of ESL days requested: _____

Employee Acknowledgement

I understand and acknowledge the following information.

- This request is subject to the terms and conditions in USM Policy VII-7.45 – Policy on Sick and Safe Leave for Non-Exempt and Exempt Staff Employees (The Policy), which I have read and understand.
- ESL may be available to an eligible employee that sustains a temporary, recoverable mental or physical illness, injury, condition, or serious disability, and who has exhausted all other forms of available leave.
- The maximum cumulative total of ESL available to an employee while in USM or State service is twelve (12) work months (52 work weeks).
- An employee requesting ESL must have a satisfactory record of work performance and no record of sick leave abuse.
- ESL is not an entitlement and my request is subject to review and approval by the Office of Human Resources (OHR) upon receipt of this signed form, supporting medical documentation from my treating health care provider, operational needs, and other terms and conditions of The Policy.

Print Name: _____

Signature and Date: _____

Department Acknowledgement

Approved Denied – Please contact your HR Partner to discuss a denied request.

Print Name: _____

Signature and Date: _____

OHR Use Only

Approved _____ Days Denied – Reason: _____

Print Name: _____

Signature and Date: _____