

Name:	Date:
Department:	AU ID: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

This form is to be used for long-term illness of employee. That includes the first day of hospitalization, out-patient surgery requiring a period of recovery, or starting with the fourth day of any period of illness.

**IMPORTANT:** The first application for long-term sick leave for an illness must be accompanied by a physician's statement which indicates the nature of the illness, disability, or incapacity and the anticipated period of absence from work.

Check only one:

- First application for this long-term illness.  
Physician's statement attached.
- A continuation of a previously reported illness under the long-term sick leave policy.

Hours Requested:

<input type="text"/>	<input type="text"/>	<input type="text"/>	0
Hours		Minutes	

Week Ending Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day	

Approval: \_\_\_\_\_  
(Department Head or Supervisor)

Signed: \_\_\_\_\_  
(Signature of Employee)

Please submit completed to Payroll Office - 0820