Colorado School of Mines

Leave Sharing Bank Program
Application for Use of Bank Leave

PART I: To be completed by employee (please type or print legibly in ink).

Name:____ CWID #:_______________

Home Address City/State/Zip: ____

Home Phone: _________________________________ Work Phone:_______________________

Department/Agency: Higher Education/Colorado School of Mines

CSM Department: ____

Title:_______________________ Date Service Began:______________________________

Request is for: ☐ Self ☐ Child ☐ Parent ☐ Spouse ☐ Other

Are you requesting/applying for: (if applicable)

☐ Short-term Disability ☐ Worker's Comp ☐ Disability Retirement

Number of hours requested:____

Briefly describe the nature of illness/injury or catastrophic
event:____
____
____
____
____

I hereby certify that I understand, agree to, and meet the requirements and conditions of the Leave Sharing Bank Program. Also, I hereby authorize the CSM President or his designee to obtain any necessary information concerning this application. I understand that denial of this application is not subject to grievance or appeal.

Signature of Employee:_____________________________ Date:______________________

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PART II: To be completed by Supervisor.

I hereby certify that, to the best of my knowledge, the above information is accurate. Also, I hereby certify that if the application is approved, authorization to use that leave is granted.

Signature of Supervisor:____________________________ Date:______________________

TO BE COMPLETED ONLY FOR MEDICALLY RELATED REQUESTS

PART III: Attending Physician's Statement (please type or print legibly).

NAME: ____________________________________ Phone #: ________________

Address City/State/Zip: ____

Date first consulted for this condition:____

Briefly describe the nature, diagnosis, and treatment of illness/injury:___________________
____
____
____

Anticipated duration employee is unable to work due to condition or direct care of family member
From:________________________ Through:___________________________

Signature of Physician:____________________ Date:_________________________

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PART IV: To be completed by Colorado School of Mines Human Resources Department.

The above named employee has/will have exhausted all annual and sick leave as of
__________________________.

Authorized Signature:__________________________ Date:___________________

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FOR CSM PRESIDENT USE:

Application was received on: ___________________________________

DECISION: (check one) ☐ Approve ☐ Reject

Authorized Signature:_____________________________________ Date:___________

Revised 9/01/02