

**Sick Bank Criteria Form**

Part-time

**Employee Name** \_\_\_\_\_ **Date of Hire** \_\_\_\_\_

- 1. Have you been employed with IHLS for at least one year? \_\_\_\_\_ Yes \_\_\_\_\_ No
  
- 2. Have you provided a physician's certification? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please give a brief statement why you are in need of sick benefits.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

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**To be completed by Human Resource Office**

Approved ( )      Number of Hours \_\_\_\_\_      Rate of Pay \_\_\_\_\_      Pay Date \_\_\_\_\_  
Denied ( )

**Notes:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Human Resource Representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_