



EXTENDED SICK LEAVE WITHOUT PAY REQUEST FORM (LCHR-14)

Human Resources Department
200 W. Oak St, Ste 3200
Fort Collins, CO 80521
Phone (970) 498-5970
Fax (970) 498-5980

***FORM PURPOSE:** This form is only to be used for Extended Sick Leave Without Pay (SLWOP) requests.

The employee **has exhausted** all leave balances, is unable to return to work because of a medical condition, and is requesting Sick Leave Without Pay. This is why the form includes the word "Extended." The Decision Maker has the discretion to approve or not approve this request. Per policy, medical certification is required of the employee's inability to work in order to approve SLWOP. Since the employee has no leave balances, the hours needed to cover benefits costs is not applicable.

This is a request for SLWOP, so Decision Maker approval and signature is required *.

LARIMER COUNTY OPERATING POLICIES AND PROCEDURES HUMAN RESOURCES POLICY AND PROCEDURE 331.6C SUBJECT: BENEFITS

- 3. Sick Leave Without Pay** (in non-FMLA or non-Worker's Compensation situations only):
- c. When requested by a Benefited Employee, an Decision Maker or designee may grant SLWOP that extends beyond the requesting employee's entire pay period. An initial period of SLWOP may not be approved for longer than three (3) months. An extension may be approved by the Decision Maker or designee for up to three (3) months per approval, but the leave should not exceed more than twelve (12) continuous months in total. The Decision Maker or designee will base any decision to grant or deny SLWOP on the department/office's staffing needs and other appropriate considerations, including the requesting employee's duties and responsibilities, the impact on the department or office, etc.
 - e. If leave balances have been exhausted, an employee must submit their request in writing to their Decision Maker or designee using the County's Extended Sick Leave Without Pay Request form. The requesting employee must indicate the medical basis for the leave and present documentation by the appropriate health care provider of the inability to work due to medical reasons. Subsequently, additional documentation may be required, for example on a monthly basis, but no less than on a quarterly basis.

NOTE: Please attach the certification of inability to work due to medical reasons.

Employee Name: _____

Employee Email: _____

UltiPro Employee #: _____ Requested Leave Dates: From: _____ To: _____

Employee Signature: _____

Sick Leave Without Pay is: Approved Denied

Decision Maker Signature *

Date