Sick Leave Reporting Form for SFUFA Employees
(Reference: Article 44, SFUFA Collective Agreement)

TO BE COMPLETED BY CHAIR OR SUPERVISOR (Once completed, please forward this form to the Return to Work/Disability Management Office, c/o Human Resources Department, Strand Hall, Room 2101 or via email to rtwdm@sfu.ca or via fax to 778-782-6873)

EMPLOYEE’s NAME & ID#: ___________________________________________ DEPARTMENT: _________________

DATE: ______________________ (dd/mmm/yyyy)

Please check the appropriate boxes below:

□ Long Term Employee □ Limited Term Employee

□ REQUEST FOR FULL TIME SICK LEAVE □ REQUEST FOR PARTIAL SICK LEAVE

(Please refer to Article 44.13)

□ WORKLOAD APPROVAL / DEAN's SIGNATURE FOR PARTIAL SICK LEAVE (Please attach)

EMPLOYEE WAS ABSENT FROM WORK / WILL BE ON PARTIAL SICK LEAVE

From: ____________________________________  To: ____________________________________

(First day of absence or partial sick leave) (dd/mmm/yyyy)  (Last day of absence or partial sick leave) (dd/mmm/yyyy)

Has the employee claimed sick leave (full or partial) in the last two years?

□ YES □ NO □ UNCERTAIN

If you answered YES above, please list any other sick leave periods (full or partial) in the last 2 years:

___________________________________________________________________________________________________________

Please note that for sick leave longer than 2 consecutive weeks the employee may be required to provide an Attending Physician’s Statement Form. An electronic copy of the Attending Physician’s Statement form is available at: http://www.academicrelations.sfu.ca/Forms/documents/AttendingPhysicianStatementForm.pdf

NOTE: Failure to report a SFUFA employee’s sick leave may result in sick leave salary overpayment and/or failure to provide the employee with an application for Long Term Disability in a timely fashion.

HAVE YOU RECEIVED AN ATTENDING PHYSICIAN’S STATEMENT?

□ YES □ NO

If YES, please send the original to the Return to Work/Disability Management Office at rtwdm@sfu.ca

CHAIR’S/SUPERVISOR’S NAME: ____________________________________  DATE: ______________________

(Please print name)

CHAIR’S SIGNATURE: ____________________________________

TO BE COMPLETED BY THE RETURN TO WORK / DISABILITY MANAGEMENT OFFICE

Is the medical documentation provided by the Member satisfactory to the University?

□ YES □ NO

Does sick leave salary reduction apply?

□ YES □ NO

If yes, indicate applicable schedule

□ <3m □ 3m<1yr □ 1yr<5yrs □ 5yrs+

Last day of paid sick leave entitlement (dd/mmm/yyyy) _______________ Estimated RTW date? (dd/mmm/yyyy) _______________

Date sick leave ends (dd/mmm/yyyy) _______________

Completed by: ___________  Date: ______________  Cc: ___________  Dean’s Office  Payroll  Faculty Relations

(Initials)  (dd/mmm/yyyy)  (Please print name)

TO BE COMPLETED BY FACULTY RELATIONS

Date Processed _______________  By: ______________________

(dd/mmm/yyyy)  (Please print name)

August, 2019