State of Illinois
Department of Healthcare and Family Services

Sick Leave Bank Membership Application

TO BE COMPLETED BY EMPLOYEE

Last Name _____ First Name _____ Middle _____ Social Security No.(Last 4 Digits) _____

Office Name _____ Work Phone Number _____

Office Address _____ City _____ State _____ Zip Code _____

Home Address _____ City _____ State _____ Zip Code _____ Home Phone Number _____

Number of Sick Days Currently Held: _____ Number of Sick Days to be Deposited: _____

Check One: ☐ I am requesting membership in the Sick Leave Bank.

☐ I am currently a member of the Sick Leave Bank and want to deposit additional day(s) as indicated above.

By my signature, I declare that I have been employed full-time for six months or more by the State of Illinois and have at least five earned sick days accumulated.

Employee Signature _____ Date: _____

Send form to: Sick Leave Bank, Division of Personnel and Administrative Services
2946 Old Rochester Road
Springfield, IL 62703

TO BE COMPLETED BY THE PAYROLL SECTION

Request to the Agency Sick Leave Bank for Membership. ☐ Approved ☐ Denied

Date: _____

TO BE COMPLETED BY THE BUREAU OF PERSONNEL SERVICES

The Payroll Section has deducted the appropriate number of days from the employee's earned sick leave account.

Bureau of Personnel Services' Representative _____ Date: _____

Print Form