Part-Time Employee Earned Sick Leave
Time Off Request Form

Employee Name (print): _____ **Division/Department: _____**

Employee Signature: _____ **Division/Department Code: _____**

Are you a Federal Work Study Student Worker? ☐ **YES** **FWS Account CODE: 1601-607848**

NEW JERSEY EARNED SICK LEAVE LAW: -- Effective October 29, 2018, employees not covered by a collective bargaining agreement or statutory sick leave provision (NJ 18A:30), will accrue up to a maximum of 40 hours of sick time at the rate of one (1) hour for every 30 hours worked.

Absence Type	Date		Total # of Days	Hours Contact Payroll at payrolldepartment@bergen.edu or humanresourcesgroup@bergen.edu for Sick Time balance		Total Hours
	From	To		From	To	
Sick						

Check the reason you are requesting LEAVE under the NEW JERSEY EARNED SICK LEAVE LAW: For approval, the absence must be related to the reasons permitted by the New Jersey Earned Sick Leave Law.

☐ **Personal** – Diagnosis, care or treatment of – or recovery from – an employee's own mental or physical illness, including preventative medical care.

☐ **Family** – Aid or care for a covered family member during diagnosis, care or treatment of – or recovery from the family member's mental or physical illness, including preventative medical care. Covered family members include: spouse, children, parents, foster parents, siblings, grandparents, grandchildren, step-parents, step-children, in-laws, domestic partner or other person who occupies such position within the family, or a person living in the same household.

☐ **Circumstances** related to an employee's or their family member's status as a victim of domestic or sexual violence (including the need to obtain related medical treatment, seek counseling, relocate or participate in related legal services).

☐ **Public Health Emergency Closure** of an employee's workplace or of a school/childcare or an employee's child because of a public official's order relating to a public health emergency.

☐ **Time to attend** a meeting requested or required by school staff to discuss a child's health condition or disability.

Supervisor Approval/Signature:

☐ Approved ☐ Denied

Supervisor Name (print): _____ **Date: ____/____/____**

Supervisor Signature: _____

_____PAYROLL USE ONLY_____

Recorded in ADP _____ **PSL Reduced in ADP _____** **Hours Left in 20____: ____**