

SUPERIOR COURT EIB REQUEST FORM

Name: _____ Department: _____ Division: _____

Job Title: _____ Employee Number: _____ Phone #: _____

Regular Days Worked:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Reason:

- Medical (self)
- Medical (immediate family)
- Non-Medical (i.e. bereavement)

*Please indicate if EIB request is to supplement:

- Worker's Compensation Benefits
- Short Term Disability Benefits

REQUESTED DAY(S)

Date EIB Starts: _____ Date EIB Ends: _____ Total # of Hours: _____

Employee Signature

Date

Acknowledgement:

Department Head Signature

Date
