## STAFF SHORT TERM DISABILITY PAY ELECTION FORM

**SECTION ONE: (Please Print)**

Employee Name: ______________________________________ T-___________________________________

Office Number: ________________________________________ Mobile Number: _______________________

Union Designation: ______________________________ Personal Email Address: ___________________________

**SECTION TWO:**

STD Leave Start Date: ______________________________ Anticipated Return Date: ________________

I acknowledge that I must continue to pay my share of health insurance premiums during my leave. If necessary, I will make arrangements with Human Resources for payment.

I acknowledge that I must exhaust all of my accrued SICK days (with an option to reserve 40 hours in my sick bank) and will receive 100% pay during the period of disability leave. Once these sick days are exhausted, I can request to use vacation/personal days in order to receive 100% pay during the period of disability leave. Once I have exhausted