UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER

Reset form

Request for Payment of Year-end Unused Sick Time Off

Overview

Information about eligibility to participate in the "Attendance Incentive Program" is available at: https://hr.uw.edu/ops/holidays-time-off/attendance-incentive-program/

If an accommodation is needed in the completion and submission of this form, please contact Medical Centers Human Resources at aaip@uw.edu.

Eligibility

To be eligible for sick time off payment, the employee:

- Must have a sick time off balance exceeding 480 hours;
- Must have accrued more hours of sick time off than were used in the previous calendar year;
- Must retain a balance of 480 hours of sick time off after receiving payment for unused sick time off.

Only sick time off accrued in the previous calendar year is eligible for payment. Therefore, the maximum number of sick time off hours for which payment can be made is 96 (e.g., 12 mos. x 8 hrs./mos. for full-time employees).

Data to complete Section 2 of the form can be found in the following manner:

- Total 12/31 year-end sick time off balance (available after 12/31 accruals load 1/5): Kronos
- Total sick time off accrued during last calendar year: 1/1 – 12/31
- Total sick leave used during last calendar year: Kronos

For help getting any of the above information, please call Payroll Services at 206-744-9280.

Department cost center(s) must be used for attendance incentive program payments. These payments are not paid centrally (unlike sick time off payments upon retirement or death which are paid centrally). The departmental cost center number(s) that are to be charged must be entered on the form at the time it is submitted. If this information is omitted, it will not be possible to process the payment request.

Routing

This form must be sent to aaip@uw.edu at least 5 working days before the last working day in January to allow time for processing. The deadline for submittal is 5 p.m. on the last working day in January.

Section 1: To be completed by the employee

1. Employee name and EID:
2. I request payment for unused sick time off accrued during the past calendar year in the amount of _____ hours (96 hrs. max). I understand that payment will equal 25% of the full-time equivalent value of the sick time off hours for which I have requested payment, and that my sick time off balance will be reduced by the total number of hours for which payment is made.
3. Employee signature and date:
4. Box number and phone number:

Section 2: To be completed by the department payroll/timekeeping staff

1. Department name and cost center:
2. Employee full-time salary rate:

Sick Time Off Payment Information	Hours (decimal)
A. Total 12/31 year-end sick time off balance	
B. Total 12/31 year-end sick time off balance minus 480	-480.00
C. Total sick time off accrued during last calendar year (96 hrs. max)	
D. Total sick time off used and/or donated as shared leave during last calendar year	
E. Net sick time off	0.00
F. Sick time off hours eligible for payment (lesser of B or E above)	
G. Sick time off hours requested for payment (less than or equal to F)	
H. Adjusted sick time off balances as of 12/31	0.00

Budgets to be Charged for Sick Time Off Payment		FTE	
LPA Cost Center No.		FTE%	0%
LPA Cost Center No.		FTE%	0%
LPA Cost Center No.		FTE%	0%
LPA Cost Center No.		FTE%	0%
LPA Cost Center No.		FTE%	0%
LPA Cost Center No.		FTE%	0%
LPA Cost Center No.		FTE%	0%

Section 3: Department Approval

1. Name of preparer/reviewer:
2. Box number and phone number:
3. Preparer/reviewer signature and date:

Confirmation

The person signing below for departmental cost center authorization confirms that the information provided is accurate and complete.

4. Name of Budget Authority
5. Box number and phone number:
6. Budget Authority signature and date: