**Completing the REQUEST FOR PAYMENT OF YEAR-END UNUSED SICK TIME OFF FORM  
for UW Medicine Staff**

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

This form is not designed to be fully completed electronically because more than one person is involved in completing the form.

1. The employee requesting payment for unused sick time off completes Section 1. 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.

**NOTE:** 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/mo for full-time employees).

2. The person responsible for the department’s time off records and/or payroll completes Section 2 and routes the form to obtain the information and approval signatures in Section 3.

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 1/5/18):   [Kronos](https://intranet.uwmedicine.org/BU/Payroll/Documents/Kronos/Kronos%20Support/How%20to%20Identify%20Accrual%20Balances.pdf)
* Total sick time off accrued during last calendar year:    1/1/17 – 5/31/17 TBA Leave Record

6/1/17 – 12/31/17 Workday

* Total sick leave used during last calendar year:  [Kronos](https://intranet.uwmedicine.org/BU/Payroll/Documents/Kronos/Kronos%20Support/How%20to%20Identify%20Sick%20Leave%20Used.pdf)

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

**IMPORTANT NOTE – 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.**

3. Route the completed form to the appropriate Human Resources Office below:

|  |  |
| --- | --- |
| Medical Centers HUMAN RESOURCES operations office | |
| **Harborview Medical Center**  **Medical Centers Human Resources Box 359715** 325 Ninth Avenue  Seattle, WA 98104-2499  Email: [aaip@uw.edu](mailto:aaip@uw.edu)  Voice: (206) 744-9220 Fax: (206) 744-9955 | **UW Medical Center**  **Medical Centers Human Resources BB150 UWMC**  **Box 356054** 1959 NE Pacific  Seattle, WA 98195  Email: [aaip@uw.edu](mailto:aaip@uw.edu)  Voice: (206) 598-6116 Fax: (206) 598-4610 |

University of Washington | Human Resources | Payroll Office

**REQUEST FOR PAYMENT OF**

**YEAR-END UNUSED SICK TIME OFF**

**UW Medicine Staff**

**Route the completed form with a copy of the sick time off record through the appropriate Human Resources Office:**

**HMC HR, Box 359715 or UWMC HR, Box 356054, or Email** [**aaip@uw.edu**](mailto:aaip@uw.edu)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| section i – completed by employee | | | | | | | | | | | |
| Employee Name | | | Employee ID Number | | | | | | | | |
| 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. | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employee Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | | | | | | Box Number | | | Phone | |
| **SECTION 2 – TO BE COMPLETED BY DEPARTMENT PAYROLL/TIMEKEEPING STAFF** | | | | | | | | | | | |
| Department Name | | Cost Center | | | | | | Employee Full Time Salary Rate | | | |
|  | | | | | | | | | | | |
| **SICK TIME OFF PAYMENT INFORMATION** | **HOURS**  **(decimal)** | | |  | **BUDGETS TO BE CHARGED FOR SICK TIME OFF PAYMENT** | | | | | | |
| 1. Total 12/31 year end sick time off balance |  | | |  | LPA Cost center No. | | | | | | FTE % |
| 2. Total 12/31 year end sick time off balance minus 480 |  | | |  |  | | | | | |  |
| 3. Total sick time off accrued during last calendar year (96 hrs. max. |  | | |  | LPA Cost center No. | | | | | | FTE % |
| 4. Total sick time off used and/or donated as shared leave during last calendar year |  | | |  | LPA Cost center No. | | | | | | FTE % |
| **STOP HERE** if #2 is less than or equal to 0, or if #4 is more than #3. You are not eligible for payment of sick time off |  | | |  | LPA Cost center No. | | | | | | FTE % |
| 5. Subtract #4 from #3 = Net Sick Time off |  | | |  | LPA Cost center No. | | | | | | FTE % |
| 6. Sick time off hours eligible for payment  (lesser of #2 or #5 above) |  | | |  | LPA Cost center No. | | | | | | FTE % |
| 7. Sick Time off hours requested for payment (less than or equal to #6) |  | | |  | LPA Cost center No. | | | | | | FTE % |
| Adjusted sick time off balance as of 12/31/\_\_\_\_\_\_ (#1 - #7) |  | | |  |  | | | | | |  |
| **SECTION 3 – DEPARTMENT APPROVAL** | | | | | | | | | | | |
| Name of Preparer/Reviewer | | | | | | Box Number | | | Phone Number | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preparer/Reviewer Signature | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | | |
| **This form must be received by Medical Centers Payroll Services, Box 359749, by 5 p.m. on the last working day in January.**  Ensure that the completed form is received in the appropriate UW Medicine HR Operations Office at least 5 working days before the last working day in January to allow time for processing. | | | | | | | | | | | |
| **The person signing below for departmental cost center authorization is confirming that the information provided is accurate and complete.** | | | | | | | | | | | |
| Name of Budget Authority | | | | | | Box Number | | | Phone Number | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Budget Authority Signature | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | | |