EMPLOYEE REQUEST TO CONVERT VACATION DAYS TO PAID SICK DAYS

Occupational Health & Wellness (OHW)

Phone: 519-824-4120 ext. 52647, Fax: 519-780-1796, Email: ohw@uoguelph.ca

In accordance with the Human Resources Policies (103 and 204) and the agreements in place with its various trade Unions and Employee Groups the University will approve requests to convert a period of vacation to paid sick leave in situations when they have a period of certified illness or injury while on their vacation. This allows the employee to have some or all of their vacation time for that period reimbursed. In order for a request to be considered the employee and their treating medical practitioner must fully complete the information as set out below and submit the information directly to the University's Occupational Health and Wellness unit.

The employee seeking vacation to sick day conversion must obtain medical documentation completed by the medical practitioner prior to making a request to convert vacation days/credits to paid sick days. Please note only legible forms written in English completed by a qualified medical practitioner will be accepted.

Section A: Employee Information

(To be completed by Employee)

Name (Surname): _____ (Given Name): _____

Home Address: (Street, City, Postal Code): _____

_____

Date of Birth (YYYY-MM-DD): _____ Phone Number: _____

Manager/Supervisor's Name: _____ Phone Number: _____

Approved Vacation Period: _____

Vacation Days Being Requested to be Converted to Paid Sick Days: _____

Section B: Medical Information

(To be completed in English by a qualified Medical Practitioner)

Please be advised that all information requested must be **fully** completed to ensure the employer can assess the employee request to convert the above stated vacation days to sick days.

Date employee was initially seen: _____

Date(s) subsequently examined: _____

General Nature of illness of injury: _____

a) Was the Employee under your direct, continuous (as applicable) and evidence based care during this period?

☐ **Yes** ☐ **No**

If NO, please provide explanation: _____

_____

b) Was the Employee admitted to hospital for this condition?

☐ **Yes** ☐ **No**

If YES, please indicate date(s) of hospital stay: _____

_____

c) Was the Employee confined to their hotel room or home for this condition?

☐ **Yes** ☐ **No**

If YES, please indicate date(s) this was in effect: _____

_____

d) Was the Employee unfit to travel by air or to operate a motorized vehicle?

☐ **Yes** ☐ **No**

If YES, please indicate date(s) this was in effect: _____

_____

e) If you answered NO to any of the above questions, please provide a general statement as to the severity of your patient's illness or injury/ total disability in order to assist the University in assessing their request to have their vacation converted to paid sick time during this period.

_____

_____

_____

_____

Section C: Please Print and Sign

(to be signed by a qualified Medical Practitioner)

By affixing my signature below, I certify that I am a qualified medical practitioner and that I have personally examined, assessed and treated the above patient/employee during the period of illness or injury. It is my opinion that the information contained in this form is true and accurate.

Practitioner Name (Please Print): _____

Discipline/Credentials: _____

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

Any cost related to providing the above information, is the responsibility of the employee.