Arkansas Association of Correctional Employees Trust

EMPLOYEE ASSISTANCE REQUEST FORM B

EMPLOYEE INFORMATION

Illness/Injury or Medical-Related Request

1. Leave Balances Annual _____ Sick _____ Holiday _____ Comp/OT _____

2. What type of insurance plan does the employee have? (Health/Home) _____

A. Is the employee on Leave Without Pay (LWOP) and/or is in danger of his/her insurance lapsing? ☐Yes ☐No

Death Related Request

1. Did the employee or immediate family of the employee have life insurance? ☐Yes ☐No

2. Are there other expenses? (please list) ☐Yes ☐No ☐Doesn't Apply

_____

_____

REVIEWING AUTHORITIES

SUPERVISOR RECOMMENDATIONS

☐Recommended ☐Not Recommended (Warden, Administrator, or Area Parole Manager)

_____ _____

Print Name Signature

If Not Recommended, reason? _____

ASSOCIATION STAFF ONLY

TO BE COMPLETED BY ARKANSAS ASSOCIATION OF CORRECTIONAL EMPLOYEES TRUST REVIEW COMMITTEE

_____ ☐Recommended ☐Not Recommended
(Association Executive Director)

_____ ☐Recommended ☐Not Recommended

_____ ☐Recommended ☐Not Recommended

Date Reviewed:_____ Amount of Assistance Sent: _____

Check Number:_____ Date Assistance Sent: _____