

**OFFICE OF HUMAN RESOURCES
REQUEST TO USE SICK LEAVE POOL HOURS**

Employee Name: _____

Address: _____

City: _____ State _____ Zip Code: _____

Work Phone: _____ Home Phone: _____

Classification: _____ Status: _____ N number: _____

Department: _____

Date Absence Began: _____

Sick Leave Pool Usage Requested: From: _____ To: _____

(Member must deplete or will have depleted all accrued, sick leave, compensatory time, special compensatory, annual leave and personal holiday prior to being granted the use of Pool hours.)

Certification of Health Care Provider Attached: _____

(Sick Leave Pool Committee will not consider Application until Medical Certification is received. Pool benefits may be retroactive to the first day of the absence if approved by Committee.)

Signature Date

TO BE COMPLETED BY HUMAN RESOURCES:

- Applicant is currently an active member of the Sick Leave Pool.
- Applicant has, or will have, depleted all personal annual, compensatory and sick leave.
- Human Resources has received a completed *Certification of Health Care Provider*.
- Applicant is not receiving disability benefits under a university or government program.
- Verified request does not exceed lifetime maximum of 480 hours or 240 hours in a consecutive twelve (12) month period.

SICK LEAVE POOL COMMITTEE DECISION: _____

Disapproved Because: _____

TOTAL SICK LEAVE HOURS APPROVED: _____

LENGTH OF TIME APPROVED: From: _____ To: _____

Administrator, Sick Leave Pool Committee Date

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