SICK LEAVE POOL REQUEST FORM

Employee Name: _____
CWID: _____
Title: _____
Department: _____
Date of First Absence Due to this Illness: _____

*NOTE: ***PLEASE ATTACH COPIES OF TIMESHEETS AND/OR LEAVE REPORTS FROM TIME OF FIRST ABSENCE DUE TO ILLNESS and a PROFESSIONAL/MEDICAL CERTICICATION:***

A currently dated statement from a licensed practitioner is required. The statement must include:

(1) A statement that the benefit-eligible employee is disabled
(2) Beginning and ending date of disability
(3) Diagnosis
(4) Indication of condition on attached table

Please initial the following statements.

_____ I certify that I have a serious illness or injury.

_____ I request consideration for sick leave pool time. I authorize the Sick Leave Pool Committee to verify information to support this request.

_____ I certify that information submitted is true and correct.

_____
Employee Signature and Date

TO BE COMPLETED AND INITIALED BY HUMAN RESOURCES

Please initial the following statements.

_____ Employee ____has/____not been employed in a benefits-eligible position for more than 90 days
Date of benefits eligible service _____

_____ Employee ____is/____is not currently in a full-time or benefits-eligible position.

_____Employee ___is/____is not eligible for compensation from other college benefit plans such as LTD, STD, Worker's Compensation, etc. If eligible please list all plans and benefits percentages.

_____
HR Signature and Date