

# Sick Leave Pool Request Form

## Instructions:

Submit this form as soon as possible to Collin College, HR/Benefits Dept. for immediate review.

- An employee's supervisor or a family member may also submit a Sick Leave Pool Request Form.

Employee Name: \_\_\_\_\_ CWID: \_\_\_\_\_

Title: \_\_\_\_\_ Department: \_\_\_\_\_

## Please indicate who is submitting this form, initial the following statements and sign:

Employee

Date of 1st Absence due to this condition:

\_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ I certify that I have a serious illness or injury.

\_\_\_\_\_ I request consideration for sick leave pool time.

\_\_\_\_\_ I authorize Human Resources to verify information to support this request.

Family Member

Supervisor

Name & Phone #: \_\_\_\_\_

\_\_\_\_\_ I certify that the above referenced employee has a serious illness or injury.

\_\_\_\_\_ I request consideration of sick leave pool time for the above referenced employee.

\_\_\_\_\_ I understand Human Resources will verify information to support this request.

I certify that the information submitted is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*Requests for Sick Leave Pool will not be considered unless all required information is submitted (employee SLP Request Form & physician SLP Medical Certification Form).*

### For Human Resources Use

Please initial the following statements:

\_\_\_\_\_ Employee \_\_\_ has / \_\_\_ has not exhausted all available paid leave.

\_\_\_\_\_ Employee \_\_\_ is / \_\_\_ is not currently in a full-time or benefits-eligible position.

Date of 1<sup>st</sup> absence due to this condition:

\_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
HR Signature

\_\_\_\_\_  
Date

HR/ Benefits Dept. - - phone (972) 599-3152 - - [Benefits@Collin.edu](mailto:Benefits@Collin.edu) - - fax (972) 599-3156