

SICK LEAVE POOL REQUEST FORM

mployee Name:
WID:
itle:
epartment:
ate of First Absence Due to this Illness:
NOTE: PLEASE ATTACH COPIES OF TIMESHEETS AND/OR LEAVE REPORTS FROM TIME OF FIRST ABSENCE DUE O ILLNESS and a PROFESSIONAL/MEDICAL CERTIFICATION:
currently dated statement from a licensed practitioner is required. The statement must include:
L) 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
lease 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
O BE COMPLETED AND INITIALED BY HUMAN RESOURCES
lease initial the following statements.
Employeehas/not been employed in a benefits-eligible position for more than 90 days Date of benefits eligible service
Employeeis/is not currently in a full-time or benefits-eligible position.
Employeeis/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