SICK LEAVE POOL APPLICATION FORM

This entire application MUST be completed for consideration by the Sick Leave Pool Committee. Please print all information.

Date of Application: _____
Full Name: _____
Address: _____Phone: _____
City: _____State: _____Zip: _____
Last Day Worked: _____

Have you previously applied and been approved days from the Sick Leave Pool: ____Yes____ No

This request is due to: ____ Physical Illness ____ Injury

When did the prolonged physical illness/injury occur or first occur? _____

Thoroughly explain physical illness or injury, and how it prevents you from working (use additional sheet if needed):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

WORKERS COMPENSATION:
Is there possible workers compensation liability? ___ Yes ___ No

Current status of workers compensation claim:
____Approved ____Denied ____ Pending ____ Not Filed

I _____ verify that I have exhausted all sick and personal leave. I can also certify that all information presented to the Sick Leave Pool Committee is true, accurate, and complete to the best of my knowledge. I also understand the Sick Leave Pool Committee may require additional information prior to a final decision being made on this application. I am requesting the Sick Leave Pool Committee to consider my application for withdrawal of sick days from the sick leave pool.

_____
Signature

MEDICAL DOCUMENTATION

SICK LEAVE POOL PHYSICIAN'S STATEMENT (Return date is required)

Please print all information.
Patient's Name: _____
Address: _____
Phone:_____
City: _____State: _____Zip: _____

**The following physician's statement is to be completed by the physician only. **
Any information added to or altered by the applicant may result in immediate disqualification

Specialist/Attending
Physician's Name: _____
Name of clinic/hospital:_____
Address: _____
Phone: _____
City: _____State: _____Zip: _____

Please explain the nature of the illness or injury (Attached additional page(s) if necessary).
_____
_____
_____
_____

Does the illness or physical injury described above prevent the patient from working?
____ Yes____ No
If yes, what is the medical treatment?
_____
_____
_____
_____
_____
_____

Physician's Signature: _____ Date: _____

SICK LEAVE POOL COMMITTEE DECISION FORM

Date of Committee Review _____

Results of Committee Review: Approved _____ Denied _____

Days Awarded _____ Days Awarded Start Date (if necessary) _____

HUMAN RESOURCES COMPLETION ONLY

I verify that this employee has:

___ has exhausted/will exhaust all sick and personal leave

___ has contributed to the sick leave pool for the current year