Request to Use Pooled Leave

Name: _____

Social Security Number: _____

Department: _____

I hereby request that I be granted _____ hours from the

☐ Sick Leave Pool ☐ Compassionate Leave Pool

If requesting leave from the Sick Leave Pool:

I certify that I meet all eligibility requirements. An original doctor's statement of illness, accident, or injury from my physician, Dr. _____, is provided with this request. In addition, I hereby authorize the appropriate committee to seek additional information from the physician(s) as may be necessary.

If requesting leave from the Compassionate Leave Pool:

I certify that I meet all eligibility requirements. An original doctor's statement of illness, accident, or injury from my family member's physician, Dr. _____, is provided with this request. In addition, I hereby authorize the appropriate committee to seek additional information from the physician(s) as may be necessary.

By signing below I understand that if hours are donated to me I will have to repay ½ of the hours I use as defined by the Compassionate Leave Pool Policy.

_____ _____

Employee Signature Date

DEPARTMENT CERTIFICATION

Date absence began: _____ Dr's Certificate attached: _____

Relationship to family member (if applicable): _____

Hours used to date: _____ Annual Leave _____ Sick Leave

_____ LWOP _____ Compensatory Time

I, the undersigned, certify that the above employee has exhausted all appropriate leave, is not on Workers' Compensation, and that the department is satisfied that the reason for absence is due to a qualifying catastrophic illness or injury.

_____ _____

Department Director Signature Date

(Return this completed form along with the original doctor's statement to the Human Resources Department.)

Revised 9/7/2007