REQUEST FOR SICK LEAVE POOL

Please complete this form and return to Superintendent. An official **Sick Leave Pool Attending Physician's Statement** must also be submitted before this request can be considered. Sick leave pool shall be setup only for the catastrophic illness or injury of the employee or employee's immediate family.

Date: _____/_____/_____

Employee Name: _____

Address: _____

Telephone: _____Campus/Dept._____

Patient's name if different than above: _____

Relationship to employee: _____

I have or will have used all my available leave, as well as any compensatory time, as applicable.

I am requesting leave: Begin: _____/_____/_____ End: _____/_____/_____

Nature of illness or injury*: _____

_____

_____

Date illness began or accident occurred: _____/_____/_____

Date physician consulted: _____/_____/_____

Name, address, and phone number of attending physician: _____

_____

_____

Did the condition require hospitalization? Yes _____ No _____

If yes, please complete the following information:

Name of hospital: _____

Dates of confinement: Begin: _____/_____/_____ End: _____/_____/_____

I certify that the information given on this request for sick leave pool is accurate and true. By signing this form, I am authorizing the district to release my name when notifying district employees that a Sick Leave Pool has been established.

Signature of Employee: _____Date: _____

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* Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Approve / Deny
Superintendent Approval Signature: _____
For Payroll Department Use Only: Date Received: _____ Date Employee Enrolled in Sick Leave Pool: _____ Date Decision Communicated to District / Employee: _____ Circle one: Granted / Denied