UNIVERSITY of WEST FLORIDA | Human Resources

APPLICATION FOR USE OF SICK LEAVE POOL CREDITS

(Please Fill in on Screen and Print - Forward to Human Resources, 20E)

Last Name: _____First Name: _____Middle Initial: _____

Home Address: _____

UWF ID Number: _____ Phone Number: _____

Contact Person and Phone Number, If Other Than Employee: _____

Length of Time Requested From: _____ To: _____ Hours Requested: _____

Explanation of Request:

EACH APPLICATION MUST INCLUDE A COMPLETED ATTENDING PHYSICIAN'S STATEMENT

Is there any disability insurance benefit covering this illness? ☐ Yes ☐ No
If yes, provide name of Insurance Provider, type, and amount of coverage.

I certify that all information provided in support of this application is complete and true to the best of my knowledge. I understand that the Committee will review information of a confidential nature in order to determine my request. I acknowledge that upon the filing of my request, the Committee will receive and may obtain the necessary medical information from my physician(s). The Committee may base its determination on my physician's statement and any other information deemed relevant by the Committee in making its decision.

_____ _____
Applicant Signature Date

To be completed by Sick Pool Administrator

Requestor is currently an active participant in the Sick Leave Pool. ☐

Requestor has, or will have, depleted all personal annual, compensatory, and sick leave credits. ☐

Received completed Attending Physician's Statement. ☐

Has sick leave benefit to be authorized been coordinated with applicable disability insurance coverage? ☐

Total Sick Leave Pool credits authorized in the last 12 months.

To be completed by Sick Pool Administrator

Approved ☐ Length of Time: From: _____ To: _____

Disapproved ☐ Total Sick Leave Hours Approved: _____