

## SICK LEAVE POOL APPLICATION

**Please Print**

Name: \_\_\_\_\_ UWF ID#: \_\_\_\_\_

Department: \_\_\_\_\_ Extension: \_\_\_\_\_

Campus Address: \_\_\_\_\_

I hereby apply for membership in the University's Sick Leave Pool. I have read and understand the terms and conditions that apply to membership and I agree to follow the procedures established for participation in the Sick Leave Pool. I understand that I am required to make an initial contribution of sixteen hours\* of sick leave and subsequent contributions, if necessary, not to exceed sixteen hours per year.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\*Number of hours required for full-time employees.

The required number of hours for part-time employees is prorated based on employee's FTE.

**Return to: Human Resources  
Attendance and Leave  
Bldg. 20E/Room 117L**

*Please do **NOT** write below this line*

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**FOR SICK LEAVE POOL COMMITTEE USE ONLY**

Verification of the following information has been provided by Human Resources to establish eligibility for membership into the University's Sick Leave Pool.

Current Sick Leave Balance: \_\_\_\_\_ (hours) as of \_\_\_\_\_.

Employee meets membership eligibility requirements:      Yes              No

Employee's FTE: \_\_\_\_\_ Hours Contributed: \_\_\_\_\_ Initial Contribution Date: \_\_\_\_\_ Other: \_\_\_\_\_

Membership Approval Date: \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Sick Leave Pool Administrator

\_\_\_\_\_  
Date