



SICK LEAVE POOL REQUEST FORM

Employee Name: _____
CWID: _____
Title: _____
Department: _____
Date of First Absence Due to this Condition: _____

A currently dated statement from a licensed practitioner is required. The statement must include:

- (1) A statement that the benefit-eligible employee is disabled
- (2) Beginning and ending date of disability
- (3) Diagnosis
- (4) Indication of condition on attached table

Please initial the following statements.

_____ I certify that I have a serious illness or injury.

_____ I request consideration for sick leave pool time. I authorize Human Resources to verify information to support this request.

_____ I certify that information submitted is true and correct.

Employee Signature

Date

TO BE COMPLETED AND INITIALED BY HUMAN RESOURCES

Please initial the following statements:

_____ Employee ___ is / ___ is not currently in a full-time or benefits-eligible position.

_____ Employee ___ has / ___ has not exhausted all available paid leave (sick, vacation, personal).

HR Signature Date