POLK STATE COLLEGE

APPLICATION FOR SICK LEAVE POOL USE

Please clearly print or type the requested information.

NAME _____ EMPLOYEE ID _____

DEPARTMENT _____ TITLE _____

DESIGNATED REPRESENTATIVE* _____ PHONE NO: _____

*only when employee is medically unable to communicate decisions. Must provide medical documentation

LENGTH OF LEAVE TIME REQUESTED: From _____ To _____

REASON FOR REQUEST: _____

DO YOU HAVE DISABILITY INSURANCE TO COVER THIS ILLNESS? ☐ Yes ☐ No

IF YES, provide name of insurance provider, type and amount of coverage:

**** COMPLETED APPLICATIONS MUST INCLUDE AN ATTENDING PHYSICIAN'S STATEMENT.**

Your absence may qualify you under the Family Medical Leave Act (FMLA) and with the proper documentation, will be classified as such. Under FMLA, you are entitled to sixteen (16) weeks or 640 hours of leave each year. This time may be taken as one continuous period or intermittently and can be taken as paid leave, using your accrued leave time or as unpaid leave. If appropriate, please ask your physician to complete the enclosed FMLA form.

"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 Sick Leave Pool 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, my illness and any other information deemed relevant by the committee".

_____ _____

Signature of Applicant (or designated representative) Date

TO BE COMPLETED BY HUMAN RESOURCES:

☐ Applicant is currently an active member of the Sick Leave Pool
☐ Applicant has, or will have, depleted all vacation, personal and sick leave time
☐ Human Resources has received a completed Physician's Statement
☐ Disability Insurance coverage and FMLA has been considered along with this request for pool benefits.
☐ Verified that request does not exceed maximum 520 hours or 65 days per 12 month period or 120 days in a 5 year period.

_____ Total Sick Leave Pool hours authorized in last 12 months _____

SICK LEAVE POOL COMMITTEE DECISION: **APPROVED** ☐ **DISAPPROVED** ☐

TOTAL SICK LEAVE HOURS APPROVED _____

LENGTH OF TIME APPROVED: FROM _____ **TO** _____ (notify Payroll)

_____

_____ Date _____

Chairperson, Sick Leave Pool Committee

_____

Human Resources Representative Date

Return to: Polk State College
Office of Human Resources
999 Avenue H, NE
Winter Haven, FL 33881
Fax: (863) 297-1075

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