UNT | SYSTEM
BUSINESS SERVICE CENTER

APPLICATION FOR SICK LEAVE POOL

Part I: Completed by Employee. Return this form to Business Service Center Human Resources or Fax (940) 369-5599. Request for Sick Leave Pool must be made, if practical, at least 2 weeks prior to the date the requested leave is to begin.

Name:	**Employee ID#:**
Job Title:	**Date of Hire:**
Home Address: **Contact #:**	**Department:** **Supervisor:**
3. I request an award from the Sick Leave Pool on behalf of: **Please indicate**: ☐ Child ☐ Parent ☐ Spouse ☐ Legal Dependent	
4. Effective Date of Leave Request:	**5. Date of anticipated return to work:**

EMPLOYEE AGREEMENT:

I have read the Sick Leave Pool Policy and by my signature below I certify that this application meets the requirements of that policy. This request is for a catastrophic illness for (check one) ____ me, or ___ *an immediate family member. I understand that I must meet the requirements set out in the Sick Leave Pool policy and that the decision of the Sick Leave Pool Administrator is final. I understand that I must authorize my licensed practitioner(s) to release all necessary information requested on the Licensed Practitioner Statement form and any charges I incur for the completion of this document will be at my expense.

Employee Signature:	Date:
*If applicable, name of immediate family member:	* If applicable, relationship to employee:

Part II: Completed by Employee's Department

Date employee last worked:	
Date employee exhausted all sick leave due to **this** catastrophic illness or injury:	
Date the employee exhausted, or is likely to exhaust , all accrued and available vacation and compensatory time:	
Date the employee was, or will be, placed on Leave without Pay:	
Number of days absent from work due to **this** catastrophic illness or injury during the prior 4 months:	
Department Contact Name & Phone #:	Date:

Part III -Sick Leave Pool Administrator

SLP hours previously awarded for this illness:	Date Additional Information Requested:	Date Additional Information Received:
Eligible for SLP: __Yes __ No	Number of Days Approved:	Date employee/Dept notified:
Notes:		