

# UNT | SYSTEM™

## APPLICATION FOR SICK LEAVE POOL

**Part I:** Completed by Employee. Return this form to Human Resources Support Center, 3440 Camp Bowie Blvd – AA2, Fort Worth, TX 76107 or Fax (817) 735-7655. Request for Sick Leave Pool must be made, if practical, at least 2 weeks prior to the date the requested leave is to begin.

<b>Name:</b>	<b>Employee ID#:</b>
<b>Job Title:</b>	<b>Date of Hire:</b>
<b>Home Address:</b>	<b>Department:</b>
<b>Contact #:</b>	<b>Supervisor:</b>
<b>3. I request an award from the Sick Leave Pool on behalf of:</b> <b>Please indicate:</b> <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Dependent	
<b>4. Effective Date of Leave Request:</b>	<b>5. Date of anticipated return to work:</b>

**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 <b>this</b> 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 <b>this</b> 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:
<b>Notes:</b>		