FLORIDA ATLANTIC UNIVERSITY
SICK LEAVE POOL
MEMBERSHIP APPLICATION

Please type or print:

NAME____

Last First Middle Initial

EMPLOYEE ID (Z#)____________________________

DEPARTMENT NAME____

OFFICE LOCATION______________________________OFFICE PHONE____________________

Upon acceptance of my application for membership in Sick Leave Pool, the Department of Human Resources is authorized to deduct 16 sick leave credits from my personal sick leave balance.

I hereby certify and agree to all provisions of the Sick Leave Pool.

______________________________________ ________________

Employee Signature Date

TO BE COMPLETED BY THE DEPARTMENT OF HUMAN RESOURCES

Eligibility Requirements:

_______ Faculty, A&P, or SP Full and Part Time Employees (not TEMP)

_______ Completed one (1) year of employment with the University

_______ Has minimum of **64 hours** of unused sick leave________ Balance

Membership in Sick Leave Pool ______Approved ______Disapproved

______________________________________ ________________

Chairperson Sick Leave Pool Committee Date

Date	Authorized Initials	Hours Contributed	New Balance
		16.0	

PLEASE RETURN THIS FORM TO: Department of Human Resources, Benefits & Retirement Office, IS-4 Room 231, 777 Glades Road, Boca Raton, Florida 33431-0991

Rev 11/16/15