



FLORIDA ATLANTIC UNIVERSITY  
APPLICATION TO USE SICK LEAVE POOL HOURS

Please clearly print or type the requested information.

NAME \_\_\_\_\_ EMPLOYEE ID \_\_\_\_\_

DEPARTMENT \_\_\_\_\_ TITLE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ PHONE NO: \_\_\_\_\_

DESIGNATED REPRESENTATIVE \*(only when employee is medically unable to communicate decisions. Must provide medical documentation.)

PHONE NO: \_\_\_\_\_ EMAIL: \_\_\_\_\_

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. THE UNIVERSITY RESERVES THE RIGHT TO REQUEST A SECOND OPINION\*\***

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 twelve (12) weeks or 480 hours of leave each rolling calendar 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. Please ask your physician to complete the enclosed Certification of Health Care Provider 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, the severity of my illness and any other information deemed relevant by the committee".

Signature of Applicant (or designated representative) \_\_\_\_\_

Date \_\_\_\_\_

\*\*\*\*\*

**TO BE COMPLETED BY DEPARTMENT OF HUMAN RESOURCES:**

- \_\_\_\_ Applicant is currently an active member of the Sick Leave Pool  
\_\_\_\_ Applicant has, or will have, depleted all personal annual, compensatory, and sick leave credits  
\_\_\_\_ Human Resources has received a completed Attending Physician's Statement  
\_\_\_\_ Disability Insurance Coverage has been coordinated with Sick Leave Pool benefits  
\_\_\_\_ Verified that request does not exceed maximum 480 hours or 60 work days per 12 month period  
\_\_\_\_ Total Sick Leave Pool credits authorized in last 12 months \_\_\_\_\_

**SICK LEAVE POOL COMMITTEE DECISION:** \_\_\_\_\_ **APPROVED** \_\_\_\_\_ **DISAPPROVED**

TOTAL SICK LEAVE HOURS APPROVED \_\_\_\_\_

LENGTH OF TIME APPROVED: FROM \_\_\_\_\_ TO \_\_\_\_\_

\_\_\_\_\_  
Chairperson, Sick Leave Pool Committee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Relations Signature

\_\_\_\_\_  
Date

Return to: Florida Atlantic University  
Department of Human Resources  
777 Glades Road – IS-4, Room 231  
Boca Raton, FL 33431  
Fax: (561) 297-4220