FLORIDA ATLANTIC UNIVERSITY
APPLICATION FOR SICK LEAVE POOL HOURS

Please clearly print or type the requested information.

NAME_____ EMPLOYEE ID _____

DEPARTMENT_____ TITLE _____

HOME ADDRESS_____ PHONE NO:_____

_____

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. 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 fiscal 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

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TO BE COMPLETED BY DEPARTMENT OF HUMAN RESOUCES:

_____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 – ADM 102
Boca Raton, Fl 33431
Fax: (561) 297-4220

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