FLORIDA GULF COAST UNIVERSITY

APPLICATION FOR GRANT OF SICK LEAVE POOL CREDITS

(Please Type or Print - Forward to Pool Administrator)

Name: _____ _____ _____
Last First Middle Initial

University ID Number: _____

Home Address: _____ Phone Number: _____

Contact person, if other than employee: _____

and Phone Number: _____

Length of time requested (if Known) From: _____ To: _____

Explanation of Request: _____

_____

_____

EACH APPLICATION MUST INCLUDE A COMPLETED ATTENDING PHYSICIAN'S STATEMENT

Is there any disability insurance benefit covering this illness? YES _____ NO _____ If yes, provide name of Insurance Provider, type and amount of coverage. _____

_____

I certify that all information provided in support of this application is complete and true to the best of my knowledge. I acknowledge that upon the filing of my request, the Committee will receive and may obtain necessary medical information from my physician(s) or health care provider and that the Committee will review information of a confidential nature in order to determine my request. The Committee may base its determination on my medical certification statement and any other information deemed relevant by the Committee in making its decision.

_____ Date: _____
Applicant Signature

<u>TO BE COMPLETED BY POOL ADMINISTRATOR</u>

- Requestor is currently an active participant in the Sick Leave Pool. _____
- Requestor has, or will have depleted all personal annual, compensatory and sick leave credits. _____
- Received complete Medical Certification Statement. _____
- Has sick leave benefit to be authorized been coordinated with applicable disability insurance coverage? _____
- Total Sick Leave Pool credits authorized for Pool Member. _____

SICK LEAVE POOL COMMITTEE DECISION

Approved _____ Length of time – From: _____ To: _____

Disapproved _____ Total Sick Leave Hours Approved: _____

COMMENTS: _____

_____ Date: _____
Sick Leave Pool Administrator

Distribution: Pool Administrator ---- Payroll Office ---- Employee