



SICK LEAVE POOL REQUEST FORM

Employee Name: _____

Title: _____

Department: _____

Date of First Absence Due to this Illness: _____

***NOTE: PLEASE ATTACH COPY OF A PROFESSIONAL/MEDICAL CERTIFICATION:**

A currently dated statement from a licensed practitioner is required. The statement must include:

- (1) A statement that the benefit-eligible employee is ill, injured or disabled
- (2) Beginning and ending date of illness, injury or disability
- (3) Diagnosis
- (4) Indication of condition

Please initial the following statements.

_____ I certify that I have a serious illness, injury or disability

_____ I request consideration for sick leave pool time. I authorize the Sick Leave Pool Committee to verify information to support this request.

_____ I have read and understand the Frio County Sick Leave Policy.

_____ I certify that information submitted is true and correct.

Confidentiality Clause

Information on an employee's medical condition or history will be kept separate from other employee information and maintained confidentially. Access to this information will be limited to the Human Resources. Such exams are strictly regulated by the Americans with Disabilities Act and Health Information Privacy Protection Act (HIPPA) in accordance with the HIPPA regulations.

Employee Signature and Date

TO BE COMPLETED AND INITIALED BY THE FRIO COUNTY HUMAN RESOURCES OFFICE:

Please initial the following statements.

_____ Employee ___ has/ ___ not been employed in a benefits-eligible position for more than 6 months.

Date of benefits eligible service_____

_____ Employee ___ is/ ___ is not currently in a full-time or benefits-eligible position.

_____ Employee ___ is/ ___ is not eligible for compensation from other county benefit plans such as LTD, STD, Worker's Compensation, etc. If eligible please list all plans and benefits percentages.

Signature and Date

_____ Approved _____ Denied

Hours granted _____

Explanation for denial:

Signature and Date