

CENTRAL FLORIDA COMMUNITY COLLEGE

REQUEST FOR SICK LEAVE FROM THE SICK LEAVE POOL

Name of Employee: _____ SSN: _____

Position Title: _____

Department/Division: _____

Employee Mailing Address: _____

Last Day Worked: _____

A catastrophic injury or illness is defined as a severe condition or combination of conditions affecting the mental or physical health of the employee:

- (1) that requires the services of a licensed practitioner;
- (2) that prevents the employee from working for a continuous period of workdays;
- (3) that forces the employee to utilize all leave time accrued by that employee (vacation leave, sick leave and compensatory time); and
- (4) which causes the employee to lose compensation.

Please describe the circumstances which qualify you to receive sick leave from the Sick Leave Pool: (Attach additional pages as needed and the physician's statement.)

I have used or anticipate using all sick and vacation leave and hereby request _____ hours from the Sick Leave Pool. I understand that only after the Human Resources Office has received the medical documentation of my illness/injury (physician's certification attached) and after pertinent leave records have been verified, will my request be taken to the Sick leave Pool Committee. I verify that all information on this form is true to the best of my knowledge.

Is this the result of an on-the-job-injury? () Yes () No

Employee's Signature: _____ Date: _____

FOR HUMAN RESOURCES/PAYROLL USE ONLY

Payroll Department

Total Sick Leave Hours: _____ Total Vacation Hours: _____

Payroll Officer Signature _____ Date: _____

SLP Committee Recommendations

Qualify Does not qualify

Hours Awarded: _____

Sick Leave Pool Committee Comments:

Committee Chair Approval: _____ Date: _____

**CENTRAL FLORIDA COMMUNITY COLLEGE
SICK LEAVE POOL
CERTIFICATION OF PHYSICIAN OR PRACTITIONER**

1. Employee's Name: _____
2. Diagnosis: _____

3. Date condition commenced: _____ Probable duration of condition: _____
4. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.): Attach additional pages as needed.
 - a. By Physician or Practitioner: _____

 - b. By other health service provider if referred by Physician: _____

5. The following statement(s) apply to the employee as a result of the condition(s) listed in Item 2:
 - a. The employee may return to work on _____ (date) with no restrictions.
 - b. The employee may return to his/her regular position with the following restrictions (based on the employer's statement of essential functions of the employee's position, or, if none provided, after discussing with the employee): _____ until _____ (probable date of return to normal job duties, if applicable).
 - c. The employee may not return to work until further evaluation on _____ (date of next apt.).
 - d. Other (please explain): _____

CHECK: Yes or No in the boxes below, as appropriate:

- | | YES | NO | |
|----|--------|--------|--|
| 6. | [] | [] | Is inpatient hospitalization of the employee required? |
| 7. | [] | [] | Is employee able to perform work of any kind? |

Employee's Signature: _____ Date: _____

Signature of Physician or Practitioner: _____ Date: _____

Printed name of Physician or Practitioner: _____ Phone #() _____

Type of Practice (Specialization, if any): _____