

**SICK LEAVE POOL APPLICATION**

**Eligibility**

The employee or a member of his or her immediate family must be suffering from a catastrophic illness or injury. A catastrophic illness or injury means a severe condition or combination of conditions affecting the mental or physical health of an employee or an employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time and that requires the employee to exhaust accrued leave and to lose compensation from the College.

**Note:** Pregnancy and elective surgery are not considered severe conditions except when life-threatening complications arise from them.

**Application Requirements**

An employee is eligible to apply for the Sick Leave Pool when all of the following conditions are satisfied:

- The employee or employee's immediate family has a severe condition or combination of conditions, as defined in this procedure, that requires the prolonged care of a licensed practitioner;
- The employee has exhausted all paid leave time including compensatory time; annual leave, etc.
- The employee has exhausted all sick leave because of the condition;
- The employee has been absent from work because of the severe condition or combination of conditions for a period of (10) working days during the four month period prior to the date that use of the Sick Leave Pool becomes necessary.
- The employee has not exhausted the maximum amount of Sick Leave Pool allowed per catastrophic illness or injury; and
- The employee's condition is not an on-the-job injury covered by Worker's Compensation Insurance.

**Withdrawal from the Sick Leave Pool**

- Employees who are awarded Sick Leave Pool are eligible for up to 240 hours (30 working days).
- Employees who are awarded Sick Leave Pool complete timesheets and receive a paycheck in the same manner as when receiving Sick Leave.

**Awaiting a Sick Leave Pool Decision**

Employees who have exhausted all accrued and available leave time must be placed on Leave Without Pay pending the decision of Sick Leave Pool. Departments are responsible for placing the employee on Leave Without Pay when it becomes necessary.

**RETURN COMPLETED APPLICATION TO THE HUMAN RESOURCES DEPARTMENT**



**PART IV DEPARTMENTAL INFORMATION**

The applicant's Employing Department shall provide the following information.

1. Date the employee last physically worked due to this illness / injury: \_\_\_\_\_
2. Leave balances as of 5:00 PM on the last day the employee physically worked: \_\_\_\_\_  
 Vacation \_\_\_\_\_ Sick Leave \_\_\_\_\_ Comp Time \_\_\_\_\_ Over Time \_\_\_\_\_
3. Indicate the date the employee will exhaust all accrued and available leave balances \_\_\_\_\_
4. Has the employee been absent from work, because of the condition for which they are applying to the Sick Leave Pool, for a period of 10 working days during the 4 months prior to the need for a Sick Leave Pool award?  
 YES  NO

If YES, specify dates. \_\_\_\_\_

\_\_\_\_\_  
Department Supervisor Date

\_\_\_\_\_  
Dean Date

**PART V SICK LEAVE POOL ADMINISTRATOR**

Date of Application Review: \_\_\_\_\_

Eligibility for Sick Leave Pool Met: \_\_\_\_\_

Sick Leave Pool Hours Approved: \_\_\_\_\_

Additional Information Requested: \_\_\_\_\_

From: \_\_\_\_\_ Date: \_\_\_\_\_

Received: \_\_\_\_\_ Not Received As Of: \_\_\_\_\_

Date Submitted to Administrator: \_\_\_\_\_

**APPROVED BY:**

\_\_\_\_\_  
Sick Leave Pool Administrator Date

**ALVIN COMMUNITY COLLEGE**

**APPLICATION FOR SICK LEAVE POOL  
LICENSED PRACTITIONER STATEMENT**

I authorize my licensed practitioner, \_\_\_\_\_, to release any information requested on this form and any other pertinent information concerning my or an immediate family member's condition to Alvin Community College's Sick Leave Pool Administrator.

\_\_\_\_\_  
Employee Name / Patient's Name (If different from employee)

\_\_\_\_\_  
Employee's Signature / Patient Signature

\_\_\_\_\_  
Date

**Licensed Practitioner Information** (To be completed by Licensed Practitioner) *Please Print or Type*

The employee has applied to the College's sick leave pool for benefits. The information requested is solely for the purpose of determining eligibility, and if eligible, the amount of time to be awarded to the employee.

Patient Name: \_\_\_\_\_

1. What is the severe condition or combination of conditions?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the treatment elective or not?  Yes  No

2. Probable duration of severe condition or combination of conditions?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Would the severe condition or combination of conditions result in death if not treated promptly?  Yes  No

If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Would the severe condition or combination of conditions cause a person to be legally declared a danger to himself or others?

Yes  No

If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Date Patient was last examined: \_\_\_\_\_

6. Additional Information (attach separate sheet if necessary) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please Print or Type

Licensed Practitioner's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

\_\_\_\_\_  
Licensed Practitioner's Signature

\_\_\_\_\_  
Date