



# Request to Use Pooled Leave

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

Social Security Number: \_\_\_\_\_

Department: \_\_\_\_\_

I hereby request that I be granted \_\_\_\_\_ hours from the

Sick Leave Pool

Compassionate Leave Pool

If requesting leave from the Sick Leave Pool:

I certify that I meet all eligibility requirements. An original doctor's statement of illness, accident, or injury from my physician, Dr. \_\_\_\_\_, is provided with this request. In addition, I hereby authorize the appropriate committee to seek additional information from the physician(s) as may be necessary.

If requesting leave from the Compassionate Leave Pool:

I certify that I meet all eligibility requirements. An original doctor's statement of illness, accident, or injury from my family member's physician, Dr. \_\_\_\_\_, is provided with this request. In addition, I hereby authorize the appropriate committee to seek additional information from the physician(s) as may be necessary.

By signing below I understand that if hours are donated to me I will have to repay ½ of the hours I use as defined by the Compassionate Leave Pool Policy.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## DEPARTMENT CERTIFICATION

Date absence began: \_\_\_\_\_ Dr's Certificate attached: \_\_\_\_\_

Relationship to family member (if applicable): \_\_\_\_\_

Hours used to date: \_\_\_\_\_ Annual Leave \_\_\_\_\_ Sick Leave  
\_\_\_\_\_ LWOP \_\_\_\_\_ Compensatory Time

I, the undersigned, certify that the above employee has exhausted all appropriate leave, is not on Workers' Compensation, and that the department is satisfied that the reason for absence is due to a qualifying catastrophic illness or injury.

\_\_\_\_\_  
Department Director Signature

\_\_\_\_\_  
Date

(Return this completed form along with the original doctor's statement to the Human Resources Department.)