UF | Office of Human Resource Services
UNIVERSITY of FLORIDA

APPLICATION TO USE SICK LEAVE POOL CREDITS

PLEASE PRINT OR TYPE:

Name: _____
(Last) **(First)** **(MI)**

UFID: _____ **Home Phone Number:** _____

Home Address: _____

Name of Applicant's Designee (if applicable): _____

Designee's Phone Number: **Home:** _____ **Work:** _____

Length of Time Requested: **From:** _____ **To:** _____

How has this condition had a major impact on your life-functions?

_____

_____

_____

_____

_____

Is there any disability insurance benefit covering this illness? **Yes** ☐ **No** ☐

If yes, please provide name of insurance provider: _____

Type of coverage: _____

I certify the information provided above is complete and true to the best of my knowledge. I understand that sick leave pool hours are granted only for personal catastrophic illnesses or injuries. Catastrophic illness or injury, as defined by the pool, is a severe condition or combination of conditions affecting the mental or physical health of an employee, which has resulted in a life-threatening condition or has had a major impact on life-functions. I further understand that if the diagnosis of my medical condition as described by my licensed medical practitioner changes, and as a result, my condition no longer meets the criteria for a catastrophic illness or injury, I may be required to submit updated medical certification and/or return to the pool any sick leave pool hours already granted. I also acknowledge that the granting of sick leave pool hours in no way limits the university's rights to proceed with any employment or disciplinary action. Should I retire, transfer, resign or be terminated from University of Florida employment, I understand that I will be terminated from the sick leave pool effective on the date of the personnel action. Any unused pool hours I may still have on that date will be returned to the pool.

_____	_____	_____
Printed Name of Applicant/Designee	**Signature**	**Date**
_____	_____	_____
Printed Name of Immediate Supervisor	**Signature**	**Date**
_____	_____	_____
Printed Name of Dean, Director, Department Chair	**Signature**	**Date**

Rev. 02/16

Certification of Medical Condition

Application to Use Sick Leave Pool Credits

Statement from Employee to Licensed Medical Practitioner

I am submitting an application for sick leave to the University of Florida's sick leave pool because of my illness or injury. I authorize any licensed medical practitioner who examines me to release the information from the examination report and any other pertinent facts concerning my condition to appropriate University of Florida sick leave pool representatives or physicians.

_____ _____

Signature of Patient/Designated Representative Date

Name of Patient:_____ UFID:_____

Licensed Medical Practitioner's Name:_____

Name of Medical Practice (if appropriate):_____

Mailing Address:_____

City:_____ State: _____ Phone Number: (____) _____

Date you first examined patient for this condition: _____

Instructions for the Licensed Medical Practitioner:

The University of Florida's sick leave pool grants sick leave hours for catastrophic illnesses or injuries. The policy defines:

A catastrophic illness or injury as a severe condition or combination of conditions affecting the mental or physical health of an employee that has resulted in a life threatening condition or has had a major impact on life-functions.

Your patient, listed above, has applied to the sick leave pool for benefits. A committee of university employees will review his/her application to determine if the request meets the condition of catastrophic illness or injury. This Certification of Medical Condition is crucial in making that determination.

Your careful response to each question below would be greatly appreciated.

Please provide information about the nature of the illness or injury:

a. Recap of all relevant medical history:

_____

_____

_____

_____

_____

_____

Name of Patient:_____ UFID:_____

b. **What treatment was/is being prescribed** (Anticipated follow-up surgery/procedures dates):

_____

_____

_____

c. **Prognosis for recovery and returning to work**:

_____

_____

_____

A catastrophic illness or injury is defined as a severe condition or combination of conditions affecting the mental or physical health of an employee that has resulted in a life threatening condition or has had a MAJOR IMPACT ON LIFE-FUNCTIONS.

How does the patient's condition qualify as **catastrophic** as defined above? (Please be specific)

a. **Is the condition/illness life threatening**? ☐ Yes ☐ No

b. **If not, how has it had a major impact on life-functions**?

_____

_____

_____

What are the current medical restrictions and their anticipated duration?

_____

_____

_____ _____

Anticipated date patient will be able to return to work:

- Limited Duty:_____
- Full Duty: _____

_____ _____

Licensed Medical Practitioner's Signature Date