INSTRUCTIONS

The application that follows is in three parts:

Section I: Department Agreement - (Page 1)

- Reviewed by you, the employee
- Completed by leaders in your department, after careful review of the information presented
- **This page should be presented to your department *without* the following pages attached**

Section II: Employee Agreement - (Page 2)

- Completed by you, the employee, after careful review of the information presented
- **This page *should not* be presented to your department along with Section I**

Section III: Certification of Medical Condition - (Pages 3-4)

- Reviewed and signed by you, the employee
- Completed and signed by a Licensed Healthcare Provider
- **These pages *should not* be presented to your department along with Section I**

The information enclosed in this application will be reviewed by the appointed Sick Leave Pool Administrator. They will contact you via the information you included on the form with any questions regarding the information enclosed (last day worked, projected date of return, nature of effect on daily life, etc.): an incomplete application will delay the processing of your request. Once all information is confirmed, your application will be shared with the committee chair. This individual will then present all relevant medical information to the members of the Sick Leave Pool Committee in attendance at the next scheduled meeting. All personal information (including UFID, name, identified sex, and job title) will be withheld from the members of the committee.

When complete, the four (4) page application packet should be sent directly to Central Leave administration. While each section of the application *can* be submitted separately (by the respective individual/area that will complete it), it *will not* be considered complete and ready for presentation to the committee *until* all three sections have been received and reviewed by the Sick Leave Pool Administrator.

If you retire, resign, or are terminated from University of Florida employment, you are no longer eligible to receive hours from the sick leave pool effective on the date of the personnel action. This is also applicable when transferring to another state agency or to an OPS appointment.

PLEASE NOTE: Submitting the application that follows *does not* initiate the process of a formal leave from the University, including leave under the Family Medical Leave Act (FMLA).

The granting of sick leave pool hours in no way limits the university's rights to proceed with any employment or disciplinary action: the granting and use of sick leave pool credits does not guarantee continued employment or extend any protections granted by any other policy, regulation, or laws.

The application for and granting of Sick Leave Pool credits has *no relation* to a formal leave from the university, including leave protected by the Family Medical Leave Act.

If you are requesting Sick Leave Pool credits and are not aware of your leave/FMLA status or have further questions about the process, you are strongly encourage to visit the UFHR FMLA webpage or to contact Central Leave at central-leave@ufl.edu or 352-392-2477.

SECTION I: Department Agreement
(to the attention of the EMPLOYEE, to be completed by the DEPARTMENT)

PLEASE PRINT OR TYPE:

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

UFID: _____

The applying employee and department administrators signing below should note the terms of a Sick Leave Pool grant of hours, and how it is distinguished from a formal university leave:

If granted, the above employee's request to use Sick Leave Pool credits would grant the employee additional leave hours to use due to absence from work related to a personal catastrophic illnesses or injuries, despite having exhausted their personal accrued leave balances: 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 a major impact on life-functions."

The granting of sick leave pool hours in no way limits the university's rights to proceed with any employment or disciplinary action: the granting and use of sick leave pool credits does not guarantee continued employment or extend any protections granted by any other policy, regulation or laws.

This application is entirely separate from a request for leave pursuant to the Family and Medical Leave Act (FMLA). Any action related to the FMLA-protected leave, or the process for an employee requesting such a leave has no interaction with the Application to use Sick Leave Pool Credits form. Such requests must be separately submitted through UF Benefits, Central Leave.

While the Application to use Sick Leave Pool Credits does not require that an employee be placed on an extended leave of absence, it is likely that an employee is requesting to use credits due to an absence of more than fifteen (15) days, which would require that an employee be placed on leave through personnel action. Any questions regarding FMLA, an extended leave of absence, or how Sick Leave Pool credits would interact with an extended leave should be addressed to UF Benefits, Central Leave at central-leave@ufl.edu.

Instructions for the department:

Signed assent on this form recognizes that the employee's department and leadership is aware that the employee is experiencing a severe condition for which the employee is requesting the use of the Sick Leave Pool credits to cover potential missed pay over a period of absence. Furthermore, it is understood that credits are awarded at the sole discretion of the Sick Leave Pool Committee and the Sick Leave Pool Appeals Board.

Please note: the employee is under no obligation to elaborate upon their illness/condition beyond that they are unable to work for a duration of time described by the healthcare provider. Any further questions should be addressed to UF Benefits, Central Leave at central-leave@ufl.edu

Printed Name of Immediate Supervisor	Signature	Date
Printed Name of Dean, Director, Dept. Chair	Signature	Date

SECTION II: Employee Agreement
(to be completed by the EMPLOYEE)

PLEASE PRINT OR TYPE:

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

UFID: _____ Personal 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?

Please provide specific information regarding your *diagnosis* and how it affects your *ability* to perform the duties required by your *job*, as well as the impact this condition has had on your *daily life*. (Add attachment if additional detail is required)

_____

_____

_____

_____

_____

(Add attachment if additional detail is required)

Do you have disability insurance that covers this illness? Yes ☐ No ☐

If yes, please provide name of insurance provider: _____

Type of coverage: _____

By signing below, 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 a major impact on life-functions." I further understand that if the diagnosis of my medical condition as described by my licensed healthcare provider changes, and as a result, my condition no longer meets the criteria for a catastrophic illness or injury, I may be required to submit 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. The granting and use of sick leave pool credits does not guarantee continued employment or extend any protections granted by any other policy, regulation, or laws. Should I retire, transfer, resign or be terminated from University of Florida employment, I understand 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 Sick Leave Pool.

_____ _____ _____
Printed Name of Applicant/Designee Signature Date

SECTION III: Certification of Medical Condition
(to be completed by the HEALTH CARE PROVIDER)

Statement from Employee to Licensed Healthcare Provider
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 healthcare provider 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 medical providers.

_____ _____
Signature of Patient/Designated Representative Date

_____ _____
Name of Patient UFID

Licensed Healthcare Provider'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 Healthcare Provider

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 (indicate anticipated return designation)**:**

- Limited Duty: _____
- Full Duty: _____

_____ _____
Licensed Healthcare Provider's Signature Date