Sick Leave Pool Request Form

Information to be completed by Employee

NAME OF EMPLOYEE:________________________ **EID#**: __________________________

School/Department:____________________________ **Assignment** ____________________

Date of Request:________________________________ **Number of days requested**: _________

Please refer to DEC (Local) Policy for more information.

I have (or will have) used all my available sick leave days for this year.

Do you anticipate any additional days to be needed for follow-up examination or treatment?
☐ Yes _____ number of days ☐ No

Have you made claim or are you entitled to Worker's Compensation Benefits?
☐Yes ☐ No

The above requested days are needed for the reason of personal or family illness as described below from my attending physician. I hereby verify that the information given is valid to the best of my knowledge and I authorize release of my medical records to the Superintendent or designee.

____ ________________________

Employee's Signature or Designee, if necessary Date

Information to be completed by Physician

Is the health condition a **catastrophic illness or injury**? ______________________________

Identification and nature of illness and/or extent of injury (laymen's language): ____________________

____

____

Anticipated date eligible to return to work: ____

Anticipated days, if any, for follow-up examination or treatment: _______________________________

	Illness	**Accident**
When did symptoms begin?	____________________	____________________
When was patient consulted?	____________________	____________________

Printed Name of Physician(s): ____

Physician's address and phone number: _______________________________________

Signature of Physician(s): ____

HUMAN RESOURCES

2200 TAMARACK ▪ McALLEN, TEXAS 78501 ▪ (956) 618-6005 ▪ FAX (956) 618-4193

Revised 01/08/18 emg