# Sick Leave Pool Application

The Sick Leave Pool was designed be the Texas Legislature for Catastrophic illness or injury.
HR-LA-PR8 Sick Leave Pool

## Eligibility

Benefits eligible employees who accrue sick leave are eligible to apply if the employee or a member of his or her immediate family is suffering from a catastrophic illness or injury. **A catastrophic illness or injury** is a severe condition or combination of conditions affecting the mental or physical health of the employee or a member of the employee's immediate family that requires treatment by a licenced practitioner for a prolonged period and that forces the employee to exhaust all leave time earned and therefore results in loss of compensation from the State.

### A severe condition or combination of conditions is one that will:

1. Result in death is not treated promptly, or
2. Requires hospitalization for more than 72 consecutive hours, or
3. Causes a person to be legally declares a danger to him or herself or others.

**Note:** Pregnancy and elective surgery are not considered severe condition 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 policy, that requires the prolonged care of a licensed practitioner;
- The employee has exhausted all accrued paid leave time including compensatory time;
- 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 720 hours or 1/3 of the Sick Leave Pool balance, whichever is less. Part-time employees who are awarded Sick Leave Pool are eligible for an amount of hours that is proportionate to their appointment.
- Employees who are awarded Sick Leave Pool complete time sheets 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. In other words, employees are not allowed to carry a negative leave balance. Departments are responsible for placing the employee on Leave Without Pay when it becomes necessary.

**PLEASE RETURN APPLICATION and LICENSED PRACTITIONER STATEMENT TO THE OFFICE OF HUMAN RESOURCES WHEN COMPLETED**

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## Part I. Employee Information

Employee Name: _____ Empl ID: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Home Phone: _____

Department: _____ Department: _____

*I* ☐ *have* ☐ *have not received SLP for this same condition before*

## Part II. Request for Award from Sick Leave Pool

I request an award from the Sick Leave Pool on behalf of (check one) ☐ myself or ☐ an immediate family member because of a catastrophic illness or injury.

- If the request is because of an illness or injury of an immediate family member, please provide the following:
  1. The name of the ill/injured individual: _____ and
  2. The relationship to the employee: _____
- If the request is for mental condition, you **must** provide complete medical record with this application.

## Part III. Verifications

- I understand that I must meet the requirements set out in the Sick Leave Pool policy to be eligible for an award of Sick Leave Pool time.
- I understand that the decision of the Sick Leave Pool Administrator concerning my request for an award of time from the Sick Leave Pool is final.
- I understand that I must authorize my licensed practitioner to release the information requested on the Licensed Practitioner Statement form, and other necessary information, to the Sick Leave Pool Administrator and those persons who will decide on this application.

_____ _____

Employee Signature Date

## Part IV. Departmental Information (to be completed by the employee's department)

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

1. Please give the date the employee last physically worked due to this illness/injury: _____
2. Please give the following 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 Sick Leave Pool?
   ☐ Yes ☐ No Please list dates: _____

_____ _____

**Name and Phone Number of Employment Department** Date

**Box 19176 1225 W. Mitchell, Rm 212 Arlington, Texas 76019-0176 Ph 817.272.5554 Fax 817-272-7288**

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## Practitioner Statement

I authorize my licensed practitioner, _____ , to release my information requested on this form and any other pertinent information concerning my or an immediate family member's condition to The University of Texas at Arlington's Sick Leave Pool Administrator.

Patient's Signature: _____ Date: _____

Patient's Name Printed: _____ Employee's Name: _____

*(If different then Patient's name)*

The employee named above has applied to the University's Sick Leave Pool for benefits. The information requested will be used solely to determine the employee's eligibility for benefits and, if eligible, the amount of time to be awarded to the employee.

### To be completed by Licensed Practitioner

1. **Does the patient's condition qualify under any of the following? Please check all that apply:**

- ☐ Hospital Care, Dates: _____
- ☐ Absence Plus Treatment
- ☐ Pregnancy or Prenatal Care
- ☐ Chronic Condition Requiring Treatment
- ☐ Elective Treatment
- ☐ Permanent/Long-Term Condition Requiring Supervision
- ☐ Multiple Treatments (non-chromic conditions)
- ☐ Result in Death if Not Treated Promptly
- ☐ Causes a Person to be Declared a Danger to themselves or others

2. **Please check all that apply:**

If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic ☐ medical or ☐ personal needs ☐ safety ☐ transportation or ☐ psychological comfort?

3. **Due to the patient's health condition, employee is unable to work from _____to_____.**

4. **Due to the patient's health condition, provide a medical recommendation for the frequency and duration of the employee's leave (i.e. hours/day, days/week; for 3 months, 6 months, etc).**

5. **Describe the medical facts which support your certification regarding the serious health condition that impedes that impede the employee's ability to work, including date the condition commenced.**

***Note:*** *Please attach supporting documentation if needed.*

6. **Date of next scheduled appointment_____.**

Licensed Practitioner Signature: _____ Date: _____

Printed Name: _____ Phone: _____ Fax: _____

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## Sick Leave Pool Application

### Return to Work Certification

**EMPLOYEE: PLEASE FILL OUT THE TOP PORTION AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER. THIS CERTIFICATION MUST BE PROVIDED TO YOUR DEPARTMENT PRIOR TO YOUR RETURN TO WORK.**

Employee: _____

Employee's Department: _____

Department Address: _____

Department Contact: _____

Telephone Number: _____

**HEALTH CARE PROVIDER: PLEASE COMPLETE THE FOLLOWING FOR THE EMPLOYEE ABOVE PRIOR TO THE RETURN TO WORK DATE.**

Is the employee able to resume working? ☐ Yes ☐ No ☐ Yes, with restrictions.

Employee is released to return to work effective (date): _____

Please list any restrictions or functional limitations which the department should consider:

Are the restrictions: ☐ Permanent ☐ Temporary, until (date): _____

Comments:

Name of Health Care Provider: _____

Specialty: _____

Address of Health Care Provider: _____

_____ _____

Signature of Health Care Provider Date



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