



REQUEST TO WITHDRAW LEAVE FROM SICK LEAVE POOL

Last Name: _____ First Name: _____ SFC ID#: _____

Number of hours requested from pool: _____

Date sick leave depleted: _____

Describe illness/disability/injury: _____

I hereby request the withdrawal of _____ hours, from the Sick Leave Pool due to the above described qualified medical event. The event qualifies as a catastrophic, non-routine illness, non planned surgery or other emergency situation. Attached is a statement from my treating physician certifying my inability to work based on the qualified medical event and providing the estimated return to work date. I authorize my physician, clinic and/or hospital to release information to substantiate my absence. I also consent to the release of this information to various SF employees who will need this information in order to determine, approve and process benefits in conjunction with this process.

Employee: _____

Date: _____

Forward to Human Resources Office

- Employee is a member of the Sick Leave Pool
- Employee has depleted all earned leave
- Assign Sick Leave Pool Request Number

Confirmed by: _____
Personnel Specialist

Date: _____

Forward to Sick Leave Pool Committee

- Application approved for withdraw of _____ days of sick leave pool beginning _____
- Application denied (reason): _____

Chairman, Sick Leave Pool Committee:

Signature

Date