The Texas A&M University System

Sick Leave Pool Form

With few exceptions, you have the right to request, receive, review and correct information about yourself collected using this form.

Name _____ UIN _____ Department _____

DONATION   Number of hours donated (in whole-day increments): _____

Note: Employees may donate an unlimited amount of their accrued sick leave each fiscal year. Donations must be made in 8-hour increments. Retiring and terminating employees may also donate sick leave to the pool. However, employees returning to state employment within 12 months (and after at least 30 calendar days if returning to the same institution or agency) will not have any donated time restored to their sick leave balances.

In making this decision I understand that it is:
- strictly voluntary,
- for use by any eligible employee, and I may not stipulate who may receive this donation, and
- no longer my property right and that my sick leave balance will be reduced by a corresponding amount.

_____   _____
Employee signature   *Date*

I certify that this employee's sick leave balance has been verified and the remaining balance may be donated to the sick leave pool.

_____   _____
Department Head signature   *Date*

WITHDRAWAL   Number of hours requested: _____
Sick leave pool withdrawals should be requested as soon as the need becomes apparent.

Purpose:

   Catastrophic illness or injury. I expect to exhaust my sick and vacation leave and compensatory time as of _____ (*time*) on _____ (*date*). I expect to have missed 80 hours of work due to this illness or injury as of _____ (*time*) on _____ (*date*). Attached is a physician's statement stating the nature and expected duration of the illness or injury.

   Noncatastrophic illness or injury. I have exhausted my sick leave and have contributed _____ hours to the sick leave pool.

   Is this request a result of an on-the-job injury? _____ yes _____ no *(Policy prohibits sick leave pool from being used in conjunction with a workers' compensation claim.)*

If requesting time to care for an immediate family member:

_____   _____
Family member's name   *Relationship*

_____   _____
Employee signature   *Date*

I certify that this employee has exhausted all earned sick and vacation leave and compensatory time as of _____ (*time*) on _____ (*date*) and that the employee has missed 80 hours of work for this condition as of _____ (*time*) on _____ (*date*).

_____   _____
Department Head signature   *Date*

Number of hours approved:_____ Comments: _____

_____   _____
Sick Leave Pool Administrator signature   *Date*