HIDALGO COUNTY
REQUEST FOR EXTENDED SICK LEAVE FORM

Name of Employee: ______________________ SSN: _______________________________

Department: _____________________________ Job Description: _____________________

Date of Request: __________________________ Number of days requested: ____________

Date of Employment: _____________________

Accumulated Leave (Hrs): A/L _________ S/L _________ C/T ________

____ ________________________________
Department Head/Supervisor Date

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

- Do you anticipate any additional days to be needed for follow-up examination treatment?
  Yes ________ No ________
- Have you made claim or are you entitled to Worker's Compensation Benefits?
  Yes ________ No ________
- Did you attach a completed P-2 form to your request?
  Yes ________ No ________

The above requested days are needed for the reasons of personal illness as described in the attached statement from my attending physician (or on the physician's letterhead stationary).
Information to be included in the doctor's statement:

- Identification and nature of illness and/or extent of injury. (An explanation in layman's language is preferred).
- Anticipated date eligible to return to work.
- Anticipated days, if any, for follow-up examination or treatment.

The doctor's statement is attached. Yes_______ No _______

	Illness	**Accident**
When did symptoms begin?	_____________________	_______________________
When was doctor consulted?	_____________________	_______________________
Name of Physician (s):	_____________________	_______________________
Address of Physician (s):	_____________________	_______________________
Phone Number (s) of Physician (s)	__________________	_______________________

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 Pool Administrator or designee.

_____________________________ ____
Date Employee's Signature (or Designee, if necessary)

Human Resources Department Use Only:

Number of days approved as of _______________________ _______________________
Date Days

Period Covered: ____________________________________ ______________________
From To

_____________________________________ ______________________
Signature – Pool Administrator Date

_____________________________________ ______________________
Signature – Designee Date