DEPARTMENT OF HUMAN RESOURCES

505 South McColl Road, Suite A • Edinburg, TX 78539 • Tel: (956) 318-2660

REQUEST FOR SICK LEAVE POOL HOURS FORM

Name of Employee: _____

Employee Address: _____

_____

Department: _____

Date of Employment: _____

Date of Request: _____

Last 4 SSN: _____

Employee Number: _____

Job Title: _____

Number of days requested: _____

Accumulated Leave (Hrs.): A/L _____ S/L _____ C/T _____

_____ _____

Elected Official/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 _____
- ☐ Anticipated Sick Leave Pool Hours start date: _____

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.

_____ _____

Employee's Signature (of Designee, if necessary) Date

Human Resources Department Use Only:

Number of days approved as of _____ _____

Date Days

Period Covered: _____ _____

From To

_____ _____

Signature – Pool Administrator Date

_____ _____

Signature – Designee Date

FORM P-5
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