

City of San Marcos Sick Leave Pool

APPLICATION FOR SICK LEAVE POOL HOURS

Section I: Request for Leave – To be completed by the employee:

Employee Name: _____ SSN: _____

Department: _____ Position: _____

Date of Hire: ____/____/____ Phone number: _____(work) _____(home)

I am requesting leave from the Sick Leave Pool due to the catastrophic illness or injury of:

Myself Child Spouse Parent

Family member's full name: _____ and date of birth ____/____/____

Is this a work-related injury or illness? Yes No

Please specify how the illness or injury meets the definition of a catastrophic illness or injury as defined in the Sick Leave Pool Policy:

Dates and number of hours leave taken for the catastrophic illness or injury: _____

When do you expect to exhaust all accrued paid leave? _____

Are you eligible to receive any disability benefits because of this catastrophic illness or injury? (Include any group or individual disability benefits.) Yes No

If yes, list the type of benefit and monthly benefit amount: _____

I certify the information provided above is complete and true to the best of my knowledge. I understand that sick leave pool hours are granted only for catastrophic illnesses or injuries. A catastrophic injury or illness is defined as a severe condition affecting the physical or mental health which has caused the employee to expend all available paid leave (including but not limited to sick, vacation, holiday, personal leave time, old sick bank, frozen holiday and compensatory) and the injury or illness has caused the employee to be absent from work at least 80 hours during the immediately preceding twelve months. I further understand that I am required to submit updated medical certification every 30 days. If the diagnosis or severity of the condition as described by the physician changes and it no longer meets the criteria for a catastrophic illness or injury, I may be required to return leave to the pool.

Employee Signature: _____ Date: _____

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Section II: Patient Release

Name of Patient: _____ Social Security Number: _____

As the City of San Marcos employee (or family member of such employee) making application for leave from the City of San Marcos Sick Leave Pool, a voluntary leave program, due to a catastrophic illness or injury, I authorize any licensed medical practitioner who examines me to release the information from the examination report and any other pertinent facts concerning my condition to the City of San Marcos.

Patient Signature/Designated Representative: _____ Date: _____

Section III: Medical Certification – To be completed by the physician:

The City of San Marcos Sick Leave Pool grants leave when a member employee or their eligible family member has a catastrophic illness or injury. The employee listed on the front page has exhausted all of his/her paid leave and has applied to the City of San Marcos Sick Leave Pool for leave. **Please provide information below on the patient listed above and attach a summary of the patient's condition.** The summary should indicate how, if at all, this patient's condition qualifies as catastrophic. Your documentation should include information about the nature of the illness or injury, a recap of all relevant medical history, the type of treatment prescribed, and a prognosis for recovery and ability to return to work. When the employee requests leave due to their own condition, a copy of their job description will be provided.

Please note that employees may only be granted 4 weeks leave per application and an update of their condition will be needed each time they request leave from the Sick Leave Pool. The maximum amount of leave they may be granted is 12 weeks (or the equivalent number of hours) per catastrophic illness or injury.

(Please type or print legibly)

Licensed medical practitioner's name: _____

Area of Specialization: _____

Mailing address: _____

City, State, Zip: _____ Phone number: _____

Date you first examined patient for the illness or injury: _____

If the patient is a City of San Marcos employee, can he/she perform his/her regular job? ___ Yes ___ No

If no, please state if the individual can perform limited duty and advise of restrictions (use space below):

Date patient will be able to return to work: Modified Duty: _____ Full Duty: _____

Licensed Medical Practitioner's Signature

Date

HR USE: ___ Approved ___ Denied Previous hours granted for condition _____ P2K Entry: _____
Comments: _____ Date: _____ Signed: _____