UT Health San Antonio
Human Resources

Sick Leave Pool
Employee Request Form

In accordance with the state government code, The UT Health San Antonio has established a sick leave pool program to provide additional sick leave for employees entitled to accrue and take paid sick leave. The Sick Leave Pool is intended to help employees in the event of a **catastrophic, life-threatening illness or injury** that results in all leave balances being exhausted and causes a loss of compensation. More information about the Sick Leave Pool can be found in the Handbook of Operating Procedures 4.7.9.

Complete both forms and submit to:
UT Health San Antonio, Office of Human Resources, MC 7972, San Antonio, TX 78229
Fax: 210-567-6791 or **E-mail**: **HR-LeaveAdmin@uthscsa.edu**

TO BE COMPLETED BY EMPLOYEE

Name: ______________________ Employee ID Number: ______________
Address: ____
Phone Number: __________________ E-Mail: ______________________
Department: ____

Patient's Relationship to Employee: ☐ Self ☐ Spouse ☐ Parent ☐ Child

Date illness or injury began: __________ Is the illness or injury work-related? ☐ No ☐ Yes

List the dates (working days) and number of hours used due to this illness or injury:

____

____

Number of working days or hours requested: ______________________

Have you or do you plan to apply for Short-term or Long-term Disability: ☐ Yes ☐ No

Sick Leave Pool requirements must be met for an award. If denied, I may still qualify for unpaid FMLA or other leave options and should contact the Office of Human Resources to discuss all available leave options.

Employee Signature: ☐ Date: ______________

TO BE COMPLETED BY DEPARTMENT

Has the employee exhausted all paid leave? ☐ Yes ☐ No

Date on which all paid leave will be exhausted: ______________

Department Representative: ______________________ Date: ______________

OFFICE USE ONLY

☐ Approved -- Number of Hours: ________ Signature: ☐

☐ Denied Date: ______________

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Sick Leave Pool
Health Care Provider Statement

Employee Name: ______________________ Phone Number: ______________________

Patient Name (if different): ______________________

I give authorization for my physician to release medical information to the UT Health San Antonio Office of Human Resources for the purposes of requesting leave through the Sick Leave Pool program.

Patient Signature: ______________________ Date: ______________________

TO BE COMPLETED BY ATTENDING HEALTH CARE PROVIDER

1. What is the patient's condition/diagnosis? Please include other relevant medical facts, if any, related to the patient's condition (such facts may include symptoms, medication or any regimen of continuing treatment, e.g. radiation or chemotherapy appointments).

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2. Approximate date the condition(s) commenced and date(s) you treated the patient.

____

3. Was the patient recently admitted for an overnight stay in a hospital, hospice, or residential medical facility?

☐ No ☐ Yes -- Dates of Admission: ______________________

4. Is the patient currently: ☐ Hospitalized ☐ Bed Confined ☐ Home Confined ☐ Able to Work

5. What is the patient's prognosis?

____

____

6. What is the patient's anticipated return-to-work date? ______________________

Physician Name: ______________________ Phone Number: ______________________

Address: ______________________

Street City Zip Code

Physician Signature: ______________________ Date: ______________________

Revised 9/28/2018