



Human Resource Services  
The University of Texas at Austin

101 E. 27th Street • P.O. Drawer V  
Austin, Texas 78713

## The University of Texas at Austin Application for Sick Leave Pool

### Part I. Employee Information

Employee name: \_\_\_\_\_ UT EID: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Department: \_\_\_\_\_ Office Phone: \_\_\_\_\_

### Part II. Request for Award from Sick Leave Pool

I request an award from the sick Leave Pool on behalf of (check one) \_\_\_\_\_, myself or \_\_\_\_\_ an immediate family member because of a catastrophic illness or injury.

- If the request is because of an illness or injury of an immediate family member, please provide.
  - 1) The name of the ill/injured individual: \_\_\_\_\_; and
  - 2) The relationship to the employee: \_\_\_\_\_
- If the request is for mental condition, you must provide complete medical record with this application.

### Part III. Verifications

- I understand that I must meet the requirements set out in the Sick Leave Pool policy to be eligible for an award of sick Leave Pool time.
- I understand that the decision of the Sick Leave Pool Administrator concerning my request for an award of time from the Sick Leave Pool is final.
- I understand that I must authorize my licensed practitioner to release the information requested on the Licensed Practitioner Statement form, and other necessary information, to the Sick Leave Pool Administrator and those persons who will decide on this application.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

**Notice Concerning Your Information:** The Texas Public Information Act, with a few exceptions, gives you the right to be informed about the information that The University of Texas at Austin collects about you. It also gives you the right to request a copy of that information; and to have the University correct any of that information that is wrong. You may request to receive and review any of that information, or request corrections to it, by contacting the University's Public Information Officer, Office of Financial Affairs, PO Box 8179, Austin, Texas, 78713 (email: [cfo@www.utexas.edu](mailto:cfo@www.utexas.edu)).

**The University of Texas at Austin**  
**Application for Sick Leave Pool**

**Part IV. Departmental Information (to be completed by the employee's department)**

The applicant's Department or Administrative Unit shall provide the following information:

- 1) Employee's last day worked: \_\_\_\_\_
- 2) Has the employee exhausted all sick leave due to the condition for which they are applying to the Sick Leave Pool? \_\_\_\_\_ Date \_\_\_\_\_
- 3) Has the employee exhausted, or is likely to exhaust annual leave and compensatory time, due to the condition for which they are applying the Sick Leave Pool? \_\_\_\_\_
- 4) Indicate the date the employee exhausted, or is likely to exhaust all accrued and available leave balances \_\_\_\_\_ Date \_\_\_\_\_
- 5) Has the employee been absent from work because of the condition for which they are applying to the Sick Leave Pool for a period of 10 working days during the 4 months prior to the need for Sick Leave Pool? \_\_\_ Yes \_\_\_ No. Date \_\_\_\_\_

\_\_\_\_\_  
Name and phone number of department contact

\_\_\_\_\_  
Date

**Part V. Sick Leave Pool Administrator**

Date completed application reviewed: \_\_\_\_\_

Eligibility for sick leave pool met: Yes \_\_\_ No \_\_\_

Sick Leave Pool hours approved: \_\_\_\_\_

Additional information requested: \_\_\_\_\_

From: \_\_\_\_\_ Date: \_\_\_\_\_

Received: \_\_\_\_\_; Not received as of: \_\_\_\_\_

Date

Date

Date resubmitted to Administrator: \_\_\_\_\_

**The University of Texas at Austin**  
**Application for Sick Leave Pool**  
**Licensed Practitioner Statement**

I authorize my licensed practitioner, \_\_\_\_\_, to release any information requested on this form and any other pertinent information concerning my or an immediate family member's condition to the University of Texas at Austin's Sick Leave Pool Administrator.

\_\_\_\_\_  
Patient's name

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

.....  
**Licensed Practitioner Information (to be completed by licensed practitioner)**

The employee has applied to the University's sick leave pool for benefits. The information requested is solely for the purpose of determining eligibility, and if eligible, the amount of time to be awarded to the employee.

Information relating to the severe condition or combination of conditions:

- 1) What is the severe condition or combination of conditions? In the case of mental health conditions, please provide a Global Assessment of Functioning (GAF) score.  
\_\_\_\_\_  
\_\_\_\_\_
- 2) Was the treatment elective?  No.  Yes. Please provide anticipated treatment dates and schedule of treatments. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 3) Would the severe condition or combination of conditions result in death if not treated promptly?  No.  Yes. If yes, please explain or provide copies of pertinent medical documentation (i.e., lab results, admit/discharge summaries, consultations, pre-/post-operative notes, pathology reports). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 4) Did the severe condition or combination of conditions require hospitalization for more than 72 consecutive hours?  No.  Yes. If yes, please provide dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 5) How long will the severe condition or combination of conditions prevent this patient from working? \_\_\_\_\_  
\_\_\_\_\_
- 6) Date patient was last examined as an outpatient: \_\_\_\_\_
- 7) Any additional information from the outpatient visit or otherwise: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Licensed Practitioner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Licensed Practitioner Signature

\_\_\_\_\_  
Date