FLORIDA STATE COLLEGE at Jacksonville

Florida State College at Jacksonville
Sick Leave Pool – **WITHDRAWAL APPLICATION**

Employee Name: ____ DOB: ________/________/________

Sex: _____ Employee PID Number: ___________________________ Home Phone: ____________________

Home Address: ____

Job Title: ____________________________________ Work Location: ______________________________

Supervisor: ____ Supervisor's Phone: ____________________

Nature of illness, accident or injury: ____

____

Number of hours requested from the Pool: ____

Date personal sick leave account depleted: ____

Date other Board approved leave depleted: ____

I hereby make application to withdraw sick leave from the Florida State College at Jacksonville Sick Leave Pool. I have enclosed with this application a statement from my physician identifying the nature of my disability, the estimated period of time of my disability, and that I am unable to work. I hereby authorize any physician, clinic, hospital, insurance company or other organization to release any and all information regarding this disability to a Florida State College at Jacksonville Benefits Specialist.

____ _______________________________

Employee's Signature Date

Attach all information supporting this application and submit to a Florida State College at Jacksonville Benefits Specialist.

---

* * * * * * * * * **OFFICE USE ONLY** * * * * * * * * *

Employee is a member of the Sick Leave Pool: Yes ___ No ___

Employee has exhausted all relevant leave: Yes ___ No ___

Employee is not eligible for a full disability retirement: Yes ___ No ___

___ This application is approved for ______________ hours of sick leave to be withdrawn from the Pool beginning on ______________________________ through ____________________________.

___ This application is disapproved due to the following reason(s): ____

____

____

Committee Signature:

_______________________________ _______________________________ _______________________________

_______________________________ _______________________________ _______________________________

____ _______________________________

Employee Services Director Date

Human Resources Department

Florida State College at Jacksonville
Sick Leave Pool – **PHYSICIAN'S REPORT**

Employee/Patient Name: ____ PID Number: ________________

Home Address: ____

I hereby authorize my physician to release any and all information regarding my illness/condition to the Human Resources Benefits Specialist at Florida State College at Jacksonville.

____ _________________________

Employee's Signature Date

Physician's Name: ____ Telephone: ______________________

Address: ____

TO THE PHYSICIAN:

The employee named above has requested sick lea e beyond the amount of time accrued by him/her during employment. The sick leave pool contains sick leave hours donated by other Florida State College at Jacksonville employees and is managed by a committee that determines if this request is for a major or extreme illness, accident or injury or for a routine illness, accident or injury which develops unusual and/or extreme complications. Please complete this form, providing adequate detail for our committee's use in approving or denying the requested grant of sick leave time.

Without complete information, this application may be denied.

Medical Diagnosis: ____

____

Frequency, duration and severity of episodes: ____

____

The condition is: ☐ Minor ☐ Routine ☐ Major

If major, please describe. ____

____

Date of first visit for this condition: ____

Treatment plan, treatment schedule and severity or debilitating effect of treatments: ______________________________

____

Please describe extent of disability (can the employee work in a limited capacity?): ______________________________

____

Surgical procedure (if any): ____

Surgical procedure performed on (date) ________________________ was elective/non-elective. (circle one)

Prescribed time off work: Starting date: _________________________ to ending date: __________________________

____ _________________________

Physician's Signature Date

____

Physician's ID Number (Please Stamp)

Please fax or return this form to: Human Resources Department, Benefits Office, Sick Leave Pool
Florida State College at Jacksonville
501 West State Street, Jacksonville, Florida, 32202
FAX: 904-632-3329

FLORIDA STATE COLLEGE AT JACKSONVILLE IS AN EQUAL ACCESS/EQUAL OPPORTUNITY/AFFIRMATIVE ACTION COLLEGE