



Application to Withdraw Hours from the Sick Leave Pool

Part I – Completed by Employee. Return this form to your department. Give Practitioner’s Statement to Practitioner.

Name of Employee (Print):		UTD ID Number:		Department:	
Home Street	Home City, State, ZIP	Home Phone:		Office Phone:	
<p>I have read the Sick Leave Pool Policy and by my signature below I certify that this application meets the requirements of that policy. This application is for a catastrophic illness for (check one) ___me, or ___*an immediate family member. I understand that I must authorize my licensed practitioner(s) to release all necessary information to the Sick Leave Pool Administrator. I understand that the decision of the Sick Leave Pool Administrator is final.</p> <p>*Name of immediate family member: _____ *Relationship to employee: _____</p>					
Employee Signature:			Date:		
<small>With few exceptions, you are entitled on your request to be informed about the information UTD collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UTD correct information about you that is held by us and that is incorrect, in accordance with the procedures set forth in The University of Texas System Procedures Memorandum 32. The information that UTD collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.</small>					

Part II – Completed by Employee’s Department. Send this CONFIDENTIAL form to HR.

<ol style="list-style-type: none"> 1. Date employee last worked: 2. Date the employee exhausted all sick leave due to this catastrophic illness or injury: 3. Date the employee exhausted, or is likely to exhaust, all accrued and available annual leave and compensatory time due to this catastrophic illness or injury: 4. Date the employee was, or will be, placed on Leave without Pay: 5. Number of days absent from work due to this catastrophic illness or injury during the prior 4 months: 	
Name and Phone Number of Department Contact	Date

Part III – Sick Leave Pool Administrator

Date Application Received	Date Additional Information Requested:	Date Additional Information Received:
SLP Hours previously awarded for this illness:		
Eligible for SLP ___YES ___NO Effective Date (Must be one day after date in #4 above:)	Number of Days Approved:	SLP Administrator Signature and Date