

Application for Sick Leave Pool Withdrawal

Instructions:

1. Read definition of catastrophic illness / injury. Keep in mind, your illness / injury may not be determined catastrophic and your application may be denied. Note that days shall not be granted unless you have exhausted **ALL** your sick leave **and** vacation time.
2. Complete application in full and as neatly as possible. Make sure all questions are answered and return to Payroll Services / Benefits Office (room 2.208 Administration Building). If an incomplete application is received in our office, it will be returned to you and **will not** be considered until it is completed. Number of days granted and effective date **if** approved, will be based upon when the completed application is received.
3. Your application will be reviewed and processed within ten (10) working days from the date it is received. Notification of response will be sent to you in writing.
4. If approved, effective date of approval will be the latter of the following dates:
 - a. Date **ALL** leave accruals expire or;
 - b. Date application is received if all leave accruals have expired.

Example: *If **ALL** sick leave **AND** vacation accruals are exhausted prior to receipt of application, effective date of approval will be the date application was received in this office. We **CANNOT** make the effective date retroactive to when all leave accruals expired unless the application is received in the Payroll Services / Benefits Office prior to the expiration of accruals.*

5. If all days requested were not granted, a new application will need to be submitted and may require an updated physician's statement.

Return to:

**Payroll Services / Benefits Office
Room 2.208 Administration Building, Route 0140
(409) 772-2630**

Employee's Statement

(To be completed by employee)

Definition of Catastrophic Illness or Injury

A catastrophic illness or injury is a severe condition or combination of conditions affecting the mental or physical health of the employee or the employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time and that forces the employee to exhaust all leave time earned by that employee and to lose compensation from UTMB for the employee. The employee may request up to a maximum of 1/3 of the balance of days in the pool not to exceed 90 calendar days.

Employee's Name: _____ Employee #: _____

Home Address: _____

Home Phone #: _____

Application is for: Employee Employee's Dependent

Dependent's Name: _____ Relationship: _____

Department: _____ Department's Phone #: _____

Supervisor's Name: _____

Nature of Illness or Injury: _____

If application for withdrawal is pregnancy related, please indicate due date: _____

Expected length of illness or injury: _____

Number of days requested: _____ Date leave accruals expire: _____

Is this a request for withdrawal of previous donation only? _____

Have you notified your supervisor of this request? _____

Attach your doctor's statement which includes a verification of the above statements. If you wish to add additional information, attach a sheet to the application.

EMPLOYEE'S SIGNATURE DATE SIGNED

PAYROLL SERVICES / BENEFITS USE ONLY

Date application received: _____

This request has been: Approved Disapproved

Days Granted: _____ Tentative Effective Date: _____

POOL ADMINISTRATOR'S SIGNATURE DATE SIGNED

Attending Physician's and Medical Certification Statement

Family and Medical Leave Sick Leave Pool

TO BE COMPLETED BY PHYSICIAN

PLEASE PRINT OR TYPE – ALL ITEMS MUST HAVE RESPONSES TO BE CONSIDERED A COMPLETE APPLICATION

1. Employee's Name: _____
2. Patient's Name if not employee: _____
3. When did symptoms first appear or accident happen? _____
4. Date patient ceased work because of disability: _____
5. Diagnosis (including complications): _____

6. Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings): _____

7. Date of 1st visit: _____ Date of last visit: _____ Frequency: ___ Weekly ___ Monthly ___ Other
If Other, please specify: _____

8. Treatment Plan: (including surgery and medications prescribed, if any): _____

9. Physical Impairments (*As defined in Federal Dictionary of Occupational Titles)

___ Class 1 – No limitation of functional capacity; capable of heavy work*. No restrictions (0 – 10%)

___ Class 2 – Medium manual activity* (15 – 30%)

___ Class 3 – Slight limitation of function capacity; capable of light work* (35 – 55%)

___ Class 4 – Moderate limitation of functional capacity; capable of clerical / administrative / sedentary* activity (60 – 70%)

___ Class 5 – Severe limitation of function capacity; incapable of minimum (sedentary*) activity (75 – 100%)

10. Is or will hospitalization of patient be required? ___ Yes ___ No

11. Has patient been hospitalized? ___ Yes ___ No If yes, give name & address of hospital & confinement dates:

12. Has patient: ___ Recovered ___ Improved ___ Unchanged ___ Worsened

13. Is patient: ___ Ambulatory ___ House Confined ___ Bed Confined ___ Hospital Confined

14. Is patient now totally disabled from: Patient's job? ___ Yes ___ No Any other work? ___ Yes ___ No

15. Date patient became disabled due to present illness: _____

16. When do you expect a fundamental or marked change in the future? ___ 1 mo ___ 1-3 mo ___ 3-6 mo ___ Never

17. When could trial employment commence? Patient's job? ___ Full-time ___ Part-time Date: _____

Any other work? ___ Full-time ___ Part-time Date: _____

18. Please estimate patient's prognosis: _____

For Certification relating to care for the employee's seriously ill family member, complete items 19 thru 21 below as they apply to the family member.

19. Does/will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ___ Yes ___ No

20. After review of the employee's signed statement (on back) is the employee's presence necessary or would it be beneficial for the care of the patient? (this may include psychological comfort.) ___ Yes ___ No

21. Estimate the period of time care is needed of the employee's presence would be beneficial? _____

22. Remarks: _____

Physician/Practitioner's Name: _____ Field of Specialization: _____

Signature: _____ Date: _____

Address: _____ Phone #: _____

