College of Central Florida
Human Resources Department

Request for Sick Leave Pool Benefits

Instructions: This form should be completed, signed by the employee and department official, and returned to the Human Resources Department within 24 hours of the request. This request for leave should be made at least thirty (30) days prior to the need for such leave or as soon as practicable. A Practitioner's Certification Form is required for a serious health condition of the employee.

The Sick Leave Pool (SLP) is awarded to qualified employees who suffer a catastrophic injury or illness that causes the employee to exhaust all of their sick and vacation leave. Medical certification of a catastrophic injury or illness which causes an anticipated absence from work is **required.**

EMPLOYEE NAME		**EMPLOYEE ID #**	
DEPARTMENT		**HOME PHONE**	
ADDRESS		**STATE**	**ZIP**

Number of hours requesting from Sick Leave Pool_____

FOR HUMAN RESOURCES/PAYROLL **USE ONLY**

Sick Leave Balance: _____ Vacation Leave Balance_____ Leave Balance As of Date_____

Prior Hours Awarded: _____ Current Hours Allocated: _____

SLP: ☐ Qualify ☐ Does not qualify

Comments:

Approved By Committee: _____ Date: _____

Committee Chair

Employee's Comments (attach additional sheet(s) if necessary):

I attest that the information noted above is true and accurate to the best of my knowledge and that I have full intention of returning to work. I also permit the College to contact my health care provider to seek additional or clarifying information that would assist in the determination of my qualifying for the requested leave benefit(s).

_____

Employee Signature Date

Department Official: I am aware that the employee is requesting the leave benefit(s) noted above.

_____

Department Official's Signature Date

College of Central Florida
Practitioner's Certification Form
Sick Leave Pool

Section 1: TO BE COMPLETED BY EMPLOYEE:

EMPLOYEE NAME:_____ EMPLOYEE ID NUMBER: _____

My signature indicates my permission for the physician to release all information as requested on this form and for the College to contact my physician to seek additional or clarifying information that would assist in the determination of my qualifying for leave benefits.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Please return original to: CF Human Resources Department
3001 SW College RD
Ocala, Florida 34474

For questions, contact Human Resources at (352) 873-5819; fax: (352) 873-5885

Section 2: TO BE COMPLETED BY PHYSICIAN OR LICENSED PRACTITIONER (please print):

1. The attached sheet (Section 3) describes what is meant by a "**serious health condition**". Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

   (1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____, or None of the above ____

2. Describe the **medical facts** that support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

3(a) State the approximate **date** the condition commenced, and the probable **duration** of the condition (and also the probable duration of the patient's present incapacity[1] if different): _____

(b) It will be necessary for the employee: ❑ **to work intermittently ,** ❑ **to work on a less than full schedule,** **OR** ❑ **to not work at all** as a result of the condition from the time period _____ to _____ (specific dates or span of time).

(c) If the condition is a **chronic condition** (condition #4), state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**:

4(a) If additional **treatments** will be required for the condition, provide an estimate of the probable **number** of such treatments. If the patient will be absent from work or other daily **activities** because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:_____

5(a) If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to a chronic condition), is the employee **unable to perform** work or any kind? ❑ YES ❑ NO

(b) If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? ❑ YES ❑ NO

(c) If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment?** ❑ YES ❑ NO

REQUIRED FOR SICK LEAVE POOL CONSIDERATION

To the physician or licensed practitioner:

The policy defines a **catastrophic illness or injury** *as a severe condition or combination of conditions affecting the mental or physical health of the employee that requires the services of a licensed practitioner for a prolonged period of time.*

Based on the definition above, is the illness or injury of the patient considered catastrophic?

☐ **YES** ☐ **NO**

SIGNATURE OF PHYSICIAN OR PRACTITIONER: _____ **DATE:** _____

NAME OF PHYSICIAN OR PRACTITIONER (please print): _____

TYPE OF PRACTICE (Field of Specialization, if any): _____

OFFICE PHONE: _____ **OFFICE FAX:** _____

Section 3: Definitions

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

   (b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[1] under the supervision of the health care provider.

3. Pregnancy

   Only for such period of time that the employee is certified by a physician as physically unable to work. Sick leave may not be withdrawn for the purpose of childcare.

4. Chronic Conditions Requiring Treatments

   A chronic condition which:

   (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (c) May cause episodic rather than a continuing period of incapacity[1] (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

   A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).