Board of County Commissioners
Escambia County, Florida

REQUEST TO USE POOLED SICK LEAVE

NAME: _____ **SSN:** _____

JOB TITLE: _____ **DEPARTMENT:** _____

I hereby request that I be granted _____ hours of Sick Leave from the Employees' Sick Leave Pool.

I certify that I meet all eligibility requirements. Certification of illness, accident, or injury from my physician, Dr. _____ has been provided to my Department.

In addition, I hereby authorize the Sick Leave Committee to seek additional information from my physician(s) as may be necessary. I likewise authorize the Sick Leave Committee to inspect my leave records as maintained by the above Department.

_____ _____

Employee/Member Signature Date

DEPARTMENT CERTIFICATION

Date Absence Began: _____ **Dr's Certificate Attached:** ☐

HIPPA Authorization attached: ☐

Hours Used to Date: _____ **Annual/PTO** _____ **Sick Leave/ELB**

_____ **LWOP** _____ **Compensatory**

We, the undersigned, certify that the above employee has exhausted all sick, annual, and compensatory leave; is not an abuser of leave; is not on Worker's Compensation; and that the Department is satisfied that the reason for the absence is due to a qualifying catastrophic illness or injury.

_____ _____

Department Record Keeper Date

Approved: _____ _____

Department Director Date

Rev.: 11/06 Attachment (2)