

SICK LEAVE POOL INFORMATION AND APPLICATION

The Sick Leave Pool was designed by the Texas Legislature for catastrophic illness or injury.

Handbook of Operating Procedures 4.26 Sick Leave Pool

Eligibility

Benefits eligible employees who have accrued and exhausted all forms of paid leave are eligible to apply to the Sick Leave Pool if the employee or a member of his or her immediate family is suffering from a 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 a member of the employee's immediate family that requires treatment by a licensed practitioner for a prolonged period and that forces the employee to exhaust all leave time earned and therefore results in loss of compensation from the State. A severe condition or combination of conditions is one that will:

- 1. Result in death if not treated promptly, or
- 2. Requires hospitalization for more than 72 consecutive hours, or
- 3. Causes a person to be legally declared a danger to him or herself or others.

Note: Pregnancy and elective surgery are not considered severe conditions except when life-threatening complications arise from them.

Application Requirements

An employee is eligible to apply for the Sick Leave Pool when all of the following conditions are satisfied:

- The employee or employee's immediate family has a severe condition or combination of conditions, as defined in this policy, that requires the prolonged care of a licensed practitioner;
- The employee has exhausted all accrued paid leave time including compensatory time because of the condition;
- The employee must not be eligible for any form of Short Term/Long Term Disability payments from any source;
- The employee has not exhausted the maximum amount of Sick Leave Pool allowed per catastrophic illness or injury; and
- The employee's condition is not an on-the-job injury covered by Worker's Compensation Insurance.

Withdrawal from the Sick Leave Pool

• Employees who are awarded Sick Leave Pool are eligible for up to 720 hours or 1/3 of the Sick Leave Pool balance, whichever is less. Part-time employees who are awarded Sick Leave Pool are eligible for an amount of hours that is proportionate to their appointment.

Awaiting a Sick Leave Pool Decision

Employees who have exhausted all accrued and available leave time must be placed on Leave Without Pay pending the decision of Sick Leave Pool. In other words, employees are not allowed to carry a negative leave balance.

PLEASE RETURN BOTH (1) THE APPLICATION FOR SICK LEAVE POOL and
(2) LICENSED PRACTITIONER STATEMENT
TO THE OFFICE OF HUMAN RESOURCES WHEN COMPLETED



APPLICATION FOR SICK LEAVE POOL (SLP)

Part I. Employee Information:

| st Name | Firs | First Name | | ne | EMPL ID Zip Code | |
|-------------------|---|-------------------------|---|----------------------|--------------------|--|
| ome Address | | City | | State | | |
| ome Phone | Cel | l Phone | | | | |
| epartment | | | | Work Phone | | |
| | ☐ I have rece | ived SLP | ☐ I have not red | ceived SLP | | |
| t II. Request f | or Award from Sid | ck Leave Pool | | | | |
| request an award | I from the Sick Leave P strophic illness or injury | ool on behalf of (chec | k one) | an immediat | e family member | |
| | | | family member, please pr | ovide the followin | a: | |
| · | ne of the ill/injured indiv | | ·······, ·········· , ······· , ······· , ······ | | <u></u> | |
| | • | | | | | |
| 2. The rela | ationship to the employ | ee: | | | | |
| t III. Proof of I | Medical Condition | ı | | | | |
| | ust submit proof of the i | | n a licensed practitioner. F | Return the License | ed | |
| | | | formation from you or you | r healthcare provi | der. | |
| | | | | | | |
| rt IV. Verificati | | | | | | |
| | and that I must meet the ve Pool time. | e requirements set out | t in the Sick Leave Pool p | olicy to be eligible | for an award of | |
| | and that the decision of eave Pool is final. | the Sick Leave Pool A | Administrator concerning | my request for an | award of time from | |
| Practition | | l other necessary infor | oner to release the inform mation, to the Sick Leave | | | |
| | | | | | | |
| | | | | | | |

Notice Concerning Your Information: You may be entitled to know what information UT San Antonio (UTSA) collects concerning you. You may review and have UTSA correct this information according to procedures set forth in UT System BPM#32.

The law is found in sections 552.021,552.023 and 559.004 of the Texas Government Code.



APPLICATION FOR SICK LEAVE POOL - LICENSED PRACTITIONER STATEMENT

| and an | rize my licensed practitioner, y other pertinent information concerning dministrator. | g my or an imme | ediate family member's | | ease any information req e University of Texas at S | • | | | | |
|---------|---|-----------------|---|-----------|--|--------------------------------------|--|--|--|--|
| Patient | 's Name Printed | | | Emplo | yee's Name (If different f | rom Patient's name) | | | | |
| Patient | 's Signature or Parent/Legal Guardian s | Signature | | Date | | | | | | |
| | The employee named above has applying to determine the employee's | | | | | | | | | |
| To be | e completed by Licensed P | ractitioner | | | | | | | | |
| 1. | Does the patient's condition qualify under any of the following? (check all that apply) | | | | | | | | | |
| | Absence Plus Treatment | Chror | nic Condition Requiring | Treatment | Multiple Treatm conditions) | nents (non-chronic | | | | |
| | Pregnancy or Prenatal Care | Electi | ve Treatment | | Result in Death if Not Treated Promptly | | | | | |
| | Hospital Care * | | anent/Long-Term Cond iring Supervision | ition | Causes a Pers to themselves | on to be declared a Danger or others | | | | |
| | *Dates: | | | | | | | | | |
| 2. | 2. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic: Please Check all that apply: Medical needs Safety Transportation Psychological comfort | | | | | | | | | |
| 3. | Due to the patient's health condition | on, the employ | ree is unable to work | from: | | to: | | | | |
| 4. | Due to the <u>patient's</u> health conditi the employee's leave (i.e. hours/d | | | | equency and duration | of | | | | |
| 5. | Describe the medical facts which support your certification regarding the serious health condition that impede the employee's ability to work, including date the condition commenced. | | | | | | | | | |
| | Note: Please attach supporting | documentation | if needed. | | | | | | | |
| 6. | Date of next scheduled appointment | ent: | | | | | | | | |
| | Licensed Practitioner Signature | | | Date | 9 | | | | | |
| | Printed Name | | | Pho | ne | Fax | | | | |