Stephen F. Austin State University
Request for Sick Leave Pool Award

Date: _____ Social Security Number: _____

Name: _____

Address: _____

Department: _____

Title: _____

Last Day Worked: _____

Please describe the circumstances, which you believe qualify you to receive sick leave from the sick leave pool (attach additional pages as needed). You must attach the medical certification for sick leave pool award completed by a licensed practitioner. Sick leave pool award request will not be reviewed for approval without SLPA medical certification completed.

Signature of employee requesting SLPA: _____

Approved: ☐ Denied: ☐

Award approved for _____ hours beginning on _____.

Human Resources representative: _____

STEPHEN F. AUSTIN STATE UNIVERSITY
THE UNIVERSITY OF TEXAS SYSTEM ★ NACOGDOCHES, TEXAS
Human Resources
P.O. Box 13039, SFA Station • Nacogdoches, Texas 75962
Phone (936) 468-2304 • Fax (800) 435-3919 • Email hr@sfasu.edu

I authorize my licensed practitioner,_____, to release the information requested on this form, and/or any additional relevant information concerning my health condition, to the Sick Leave Pool Administrator at Stephen F. Austin State University.

Patient's Signature:_____

Date:_____

Patient's Printed Name:_____

Employee's Printed Name (if different than Patient's Name):_____

The employee identified above has applied to the University's sick leave pool for an award. The information requested will be used solely to determine the employee's eligibility for benefits and, if eligible, the number of days awarded to the employee.
1. What is your diagnosis of the severe condition or combination of severe conditions affecting this patient?
2. Do you consider the treatment to be elective? _____Yes _____No
3. Will this severe condition or combination of severe conditions result in death if not treated promptly? _____Yes. _____No. If yes, please explain:
4. Has this severe condition or combination of severe conditions required hospitalization for more than 72 consecutive hours? _____Yes _____No. If yes, please provide dates:
5. Probable duration of severe condition or combination of conditions?
6. Date patient was last examined:
7. Additional Information, if any, you (Practitioner) believe would assist in the evaluation of employee's condition severity and/or the employee's request for benefits (how his/her abilities are impacted):

Office Telephone Number:	Office Fax Number:
Licensed Practitioner Signature:	Date:

Stephen F. Austin State University
Sick Leave Pool
Return to Work Medical Certification Form

PART I: TO BE COMPLETED BY EMPLOYEE

Name of Employee (First, Middle, Last) _____

Employee's position _____

Date leave commenced _____

Date of planned return to work _____

Signature of employee _____ Date _____

PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

I certify that on _____ [Date], _____ [Name of Employee], is able to resume performing the functions of his/her position ☐ with or ☐ without limitations. Please list limitations if applicable.

Signed _____ Date _____

Health care provider's name, address & telephone number.

_____

Name Telephone

_____

Address

PART III: TO BE COMPLETED BY EMPLOYER

Employer Remarks:

This form should be sent to:

Stephen F. Austin State University
Human Resources
PO Box 13039, SFA Station
Nacogdoches, Texas 75962-3039
Fax 1-800-435-3919