

The Texas A&M University System  
Sick Leave Pool Form

Name: \_\_\_\_\_ UIN: \_\_\_\_\_ Department: \_\_\_\_\_

**DONATION** Number of hours donated (in whole-day increments): \_\_\_\_\_

*Note: Employees may donate an unlimited amount of their accrued sick leave each fiscal year. Retiring and terminating employees may also donate sick leave to the pool. However, employees returning to state employment within 12 months (and after at least 30 calendar days if returning to the same institution or agency) will not have any donated time restored to their sick leave balances.*

- In making this decision I understand that it is:
- Strictly voluntary,
- For use by any eligible employee, and I may not stipulate who may receive this donation, and
- No longer my property right and that my sick leave balance will be reduced by a corresponding amount.

\_\_\_\_\_  
*Employee signature*

\_\_\_\_\_  
*Date*

I certify that this employee's sick leave balance has been reduced by the amount donated to the sick leave pool.

\_\_\_\_\_  
*Department Head signature*

\_\_\_\_\_  
*Date*

**WITHDRAWAL** Number of hours requested: \_\_\_\_\_

Sick leave pool withdrawals should be requested as soon as the need becomes apparent. Pool hours cannot be awarded retroactively.

Purpose:

- Catastrophic illness or injury, I expect to exhaust my sick and vacation leave and compensatory time as of \_\_\_\_\_ (time) on \_\_\_\_\_ (date). I expect to have missed 160 hours of work due to this illness or injury as of \_\_\_\_\_ (time) on \_\_\_\_\_ (date). Attached is a physician's statement stating the nature and expected duration of the illness or injury.
- Noncatastrophic illness or injury. I have exhausted my sick leave and have contributed \_\_\_ hours to the sick leave pool.
- Is this request the result of an on-the-job injury? \_\_\_yes \_\_\_no (*Policy prohibits sick leave pool from being used in conjunction with a worker's compensation claim.*)

If requesting time to care for an immediate family member:

\_\_\_\_\_  
*Family member's name*

\_\_\_\_\_  
*Relationship*

\_\_\_\_\_  
*Employee signature*

\_\_\_\_\_  
*Date*

I certify that this employee has exhausted all earned sick and vacation leave and compensatory time as of \_\_\_\_\_ (time) on \_\_\_\_\_ (date) and that the employee has missed 160 hours of work for this condition as of \_\_\_\_\_ (time) on \_\_\_\_\_ (date).

\_\_\_\_\_  
*Department Head signature*

\_\_\_\_\_  
*Date*

Number of hours approved: \_\_\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_  
*Sick Leave Pool Administrator signature*

\_\_\_\_\_  
*Date*

State law requires that you be informed of the following: (1) you are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law); (2) you are entitled to receive and review that information; and (3) you are entitled to have the information corrected at no charge to you.