MEMORANDUM

TO: SICK LEAVE POOL APPLICANT
FROM: DIANNE WEAKLEY
DIRECTOR OF HUMAN RESOURCES
SUBJECT: SICK LEAVE POOL APPLICATION

In order to standardize the Sick Leave Pool application process, we have designed a three-page application form, which is enclosed.

If you find it necessary to apply for the Sick Leave Pool in the future or ask for an extension of a current approval, please complete and submit the form in a timely manner, according to the instructions. Please note that it includes a page for your attending physician’s completion.

We would also appreciate receiving back any comments from you as the end user. Your remarks will help us to better serve our employees.

Please feel free to call if you have a question. Thank you.
REQUEST FOR APPROVAL / SICK LEAVE POOL BENEFITS

Refer to MSU Sick Leave Pool Policy # 3.337

Instructions: This form should be completed, signed by the employee, the employee’s immediate supervisor, and the attending licensed practitioner and returned to the MSU Human Resources Dept. within 24 hours of the date of request. This request for leave should be made as soon as the need for such leave is apparent. **A licensed practitioner’s statement is required.**

Employee Name: ______________________________   Social Security # __________________
Street Address: _____________________________ City: _________________ State: ___ Zip: _______
Department: __________________________________  Hire Date: _________________________

Request is hereby made for approval of Sick Leave Pool benefits in accordance with the MSU Sick Pool Policy #3.337. I hereby certify that I qualify for the Sick Leave Pool based upon a catastrophic illness or injury of at least 30 days duration experienced by:
(check one)
1. ________ me, (the employee), or
2. ________ my immediate family member (see policy)

I am requesting that leave be granted as:
(check one)
1. ________ Intermittent leave or reduced work schedule for a chronic, severe medical condition requiring recurrent treatment by a licensed practitioner, or
2. ________ Continuous leave under the care of a licensed practitioner during a prolonged period of incapacity or convalescence due to a catastrophic illness.

I attest that the information is true and accurate to the best of my knowledge and that I have full intention of returning to work, if able. I request and permit my attending licensed practitioner to release additional or clarifying information to the University, which would assist in the determination of qualification for the sick leave pool benefits. I understand that I may be required to refund those benefits to the University if it is determined that I did not qualify for benefits, after having received them.

___________________________________  _____________________________
Employee’s signature                       Date

I am aware that the employee is requesting the sick leave pool benefits noted above.

___________________________________  ______________________________
Immediate supervisor’s signature             Date
(Pages 2 and 3 contain confidential medical information which is not to be provided to the supervisor.)

______________________________
HR Approval: ☐ Yes  ☐ No
By: ____________________________  Duration: ____________________________
REQUEST FOR APPROVAL / SICK LEAVE POOL BENEFITS
EMPLOYEE’S STATEMENT

To be completed by the employee

1. Describe in a brief statement, the medical facts that support the patient’s claim of a catastrophic illness.

2. State the approximate **date** the condition commenced and the probable **duration** of the condition and the incapacity.

3. Is the leave being requested in order to provide care to an immediate family member, other than the employee?

   _____ Yes   _____ No

   If yes, provide the name, address, and relationship of the family member to the MSU employee.

   If yes, is the MSU employee considered the primary care-giver of the family member?

   _____ Yes   _____ No

4. If the leave requested is to care for an immediate family member experiencing a catastrophic illness or injury, describe the type of patient assistance required of the employee, for example, basic medical or personal needs, safety, transportation to health care providers, etc.

5. **Certification of Employee**

   I attest the above statements are true and complete to the best of my knowledge.

   ___________________________  ___________________________
   Signature of Employee  Date

   ___________________________
   Printed Name

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REQUEST FOR APPROVAL / SICK LEAVE POOL BENEFITS
ATTENDING LICENSED PRACTITIONER’S STATEMENT

To be completed by attending licensed practitioner (See employee’s signed release, page one)

1. Which of the categories below best describes the patient’s condition?
   An illness, injury, impairment, or physical or mental condition involving the following:
   _____ (1) Hospital care    _____ (2) Absence plus recurrent treatment
   _____ (3) Pregnancy        _____ (4) Chronic condition(s) requiring treatments
   _____ (5) Permanent/Long-term condition requiring supervision
   _____ (6) Multiple treatments for non-chronic conditions
   _____ (7) Other (explain) __________________

2. Explain how the condition of the patient meets the criteria of the categories marked above.

3. Does the patient’s condition meet the state’s definition of a catastrophic illness or injury? (A severe condition or combination of conditions affecting the mental or physical health that requires the services of a licensed practitioner for a prolonged period of time) (30+ day’s duration)
   ______ Yes   ______ No

4. Will the patient’s condition possibly result in death if not treated promptly or on regularly scheduled intervals? (Chemotherapy treatments, etc.)   _____ Yes   _____ No
   If yes, Type of treatment: ______________________________________
   Schedule of treatments: __________________________________

5. Is the employee currently able to work his/her regular schedule?   ____Yes   ____No
   If no, please give an estimate of the leave required:
   a. The employee will need to be absent intermittently, as necessary, from ________________ through ________________ (dates).
   b. The employee will need to work on a reduced schedule beginning __________________ and may return to full duty on ________________ (dates).
   c. The employee is advised to not work at all from ________________ to ________________ (dates).

6. If the patient is NOT the MSU employee, does the patient require assistance for basic medical or personal care, transportation to medical care, or to ensure safety?   ____Yes   ____No
   If no, would the employee’s presence provide psychological comfort or be beneficial to the patient or aid the patient’s recovery?   ____Yes   ____No
   Estimated duration of care: _______________________________________ (dates)

7. Certification of attending Licensed Practitioner
   I attest the above statements are true and complete to the best of my knowledge.

   ________________________________ ________________________________
   Signature of Licensed Practitioner       Date

   ________________________________
   Printed Name

   ________________________________
   Phone #