



FLORIDA STATE UNIVERSITY  
 OFFICE OF HUMAN RESOURCES  
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**FLORIDA STATE UNIVERSITY  
 SICK LEAVE POOL PHYSICIAN'S REPORT and REQUEST TO USE HOURS**

**SECTION 1 – TO BE COMPLETED BY EMPLOYEE** (Please Print)

By submitting this request you agree to all the terms and conditions for the use of Sick Leave Pool hours as defined in FSU policy.

Name of Employee: \_\_\_\_\_ Employee ID: \_\_\_\_\_  
(9 digit OMNI number)

Home Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Home/Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

**STATEMENT FROM PARTICIPANT EMPLOYEE TO EXAMINING PHYSICIAN**

I authorize my physician to release any information requested on this form and any other pertinent information concerning my condition to the FSU Sick Leave Pool Administrator and Committee.

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
Street City State Zip Code

Signature of Participant Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 2 – TO BE COMPLETED BY PHYSICIAN** (Please Print)

**TO ATTENDING PHYSICIAN:** This application will be reviewed by the FSU Sick Leave Pool Committee (including a physician from the FSU College of Medicine) for the purpose of determining allowable paid sick leave benefits. Only fully completed applications will be considered. The Sick Leave Pool Committee is authorized to grant up to 160 Sick Leave Pool hours (20 workdays), for requests arising from catastrophic/serious personal illness, accident, or injury or combination of conditions which has a major impact on life-functions. If additional time is needed, the employee must fill out a new request form with physician's documentation. These requests must be filed on a monthly basis until the employee returns to work full time.

Date individual was first examined with this condition: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment Plan (including physical and rehabilitative therapies): \_\_\_\_\_

Employee can perform the essential function of his/her job:  YES  NO If no, explain any limitations:  
 \_\_\_\_\_  
 \_\_\_\_\_

Employee may return to work:  Full Time on (date) \_\_\_\_\_ or  Re-evaluated on (date) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**FLORIDA STATE UNIVERSITY**  
**SICK LEAVE POOL PHYSICIAN'S REPORT and REQUEST TO USE HOURS**  
(Continued)

\_\_\_\_\_  
Employee's Name (Last, First)

\_\_\_\_\_  
Employee ID and Record Number

**SECTION 3 – TO BE COMPLETED BY DEPARTMENT**

FMLA regulations require that qualifying events be reported to the University FMLA Administrator at (850)644-5051.

Department Name: \_\_\_\_\_ Campus Mail Code: \_\_\_\_\_

Department Representative's Name (Print): \_\_\_\_\_

Department Representative's Phone Number: \_\_\_\_\_

I certify that \_\_\_\_\_ will exhaust all earned sick, vacation, personal holiday  
Participant Employee's Name

and compensatory leave on \_\_\_\_\_  
Date

Department Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_