CLASSIFIED POOL RESERVE
Application for Use

PART 1 --- EMPLOYEE STATEMENT (Please type or print legibly in ink. May be completed by designee of employee.)	
Employee's Name:	
ID #:	FTE Load:
Position # and Title:	
Address:	Work Phone #:
	Home Phone #:
Department:	
Last day of Work:	Expected date of return:
Date all sick and paid leave, and compensatory time will be exhausted:	
I (√ one) □ am □ am not currently receiving, or anticipating receiving, workers' compensation and/or long-term disability insurance benefits, or any other type of income replacement.	
Number of days requested:	
Briefly describe the nature of illness/injury:	
I understand, agree to, and meet the requirements and conditions of the Pool Reserve. I authorize the Human Resources Asst. Director or designee to obtain information concerning this application. If I receive income replacement while drawing from the Sick Leave Pool, I agree to notify HR, and reimburse the Sick Leave Pool.	
Employee or designee's signature:	Date:

PART 2 – ATTENDING PHYSICIAN'S CERTIFICATION (Please type or print in ink legibly).	
Physician's Name:	
Address:	Phone #:
	Date first consulted for this condition:
Briefly describe the nature, diagnosis, and treatment of illness/injury:	
Anticipated duration employee is unable to work due to condition: From: To:	
Is inpatient hospitalization of the employee required? ☐ Yes ☐ No Comments:	
Is employee able to perform work of any kind? ☐ Yes ☐ No Comments:	
Is employee able to perform the essential functions of his/her position? (Please respond after reviewing essential functions of employee's job description) ☐ Yes ☐ No	
Physician's Signature:	Date:

PART 3 --- HR USE ONLY	
Date application received:	Date decision made:
Is employee requesting, receiving or eligible to apply for: ☐ Workers' Compensation ☐ Long-Term Disability ☐ PERS Disability ☐ Social Security Disability ☐ Other Source of Income Replacement	
All paid leave, sick leave and compensatory time have been/will be exhausted as of:	Application status (Check one) ☐ Approved ☐ Denied
	Number of hours approved:
Reason for denial:	
Date decision made:	Date employee notified:
PART 4 --- FOR APPEAL USE ONLY	
Date appeal received:	Date decision made:
Application status (Check one) ☐ Approved ☐ Denied	Number of hours approved:
Reason for denial:	
Date employee notified:	Date supervisor notified:
Classified Association Representative Signature:	Date: