City of Clearwater
CWA Sick Leave Pool
Employee Request Form

Employee's Name: _____ Employee ID #: _____ Date: _____

Department: _____

Nature of illness or injury: _____

_____

Is this a first request of this benefit? Yes _____ No _____

Is this a request for benefits for reoccurrence of condition for which pool benefits have already been received?
Yes _____ No _____

Beginning date of absence _____ Anticipated return _____

Approximate date all personal leave was /will be exhausted: _____

Expected number of days needed for pool benefits: _____

You must attach a Physician's Report of Examination and signed leave forms.

I certify that I will have utilized all accrued leave credits and my floating holidays prior to use of any pool days.

_____
Employee's Signature

****

For Sick Leave Pool Committee Use

Has employee previously received sick leave pool benefits: Yes _____ No _____

Number of days used in 12-month period _____

_____ Use of sick leave pool is approved for _____ days.

_____ Use of sick leave pool days is denied. Reason _____

****

_____ **Date** _____ **Approved** _____ **Disapproved** _____
Committee Member

_____ **Date** _____ **Approved** _____ **Disapproved** _____
Committee Member

_____ **Date** _____ **Approved** _____ **Disapproved** _____
Committee Member

_____ **Date** _____ **Approved** _____ **Disapproved** _____
Committee Member

_____ **Date** _____ **Approved** _____ **Disapproved** _____
Committee Member