CITY OF CLEARWATER

SAMP SICK LEAVE POOL REQUEST FORM

TO: **Human Resources/SAMP Sick Leave Pool Committee**

FROM: _____

DATE: _____

I hereby request to be granted _____ days of paid leave from the SAMP Sick Leave Pool. I am requesting this paid leave as a result of the following illness/injury (supporting documentation in the form of a Physician Report must be attached):

_____

_____

_____

I will be without paid leave of any kind effective the following date: _____

I understand that the decision to approve or deny this request for paid leave will be made by the SAMP Sick Leave Pool Committee and that such decision shall be deemed final and not grievable.

_____	_____
Signature	**Date**
_____	_____
Department	**Work Phone Number**
_____	_____
Employee ID Number	**Scheduled Bi-Weekly Hours**

For Committee Use Only

SAMP SICK LEAVE POOL COMMITTEE ACTION Meeting Date: _____

Request Approved: _____ Request Denied: _____

Reason: _____

_____

_____

Approved Leave Begin Date _____ Approved Leave End Date _____

City of Clearwater
SAMP Sick Leave Pool
Physician's Report
(to be completed and returned with the SAMP Sick Leave Pool Request)

Employee's Name _____

Department _____ Work Phone _____

Statement From Participant to Examining Physician

I am making application for paid sick leave to the City of Clearwater Sick Leave Pool because of my illness or injury. I authorize any physician to release information requested on this form and any other pertinent information concerning my condition.

Participants' Signature _____ Date _____

To The Attending Physician:

This individual has exhausted all of his/her paid leave and has applied to a City of Clearwater Sick Leave Pool for benefits. The information requested here is to be used solely by the City of Clearwater Sick Leave Pool Committee to determine the granting of paid sick leave pool benefits to the participant.

Please describe the nature of the employee's illness or injury

_____

_____

_____

When was the individual first examined for this condition? _____

Is the individual able to perform his/ her normal work? _____

Estimated date he/she can return to work _____

Physician's Signature _____ Date _____

Phone _____

PLEASE RETURN THIS COMPLETED FORM TO HUMAN RESOURCES