

**UNIVERSITY OF SOUTH FLORIDA  
USF SICK LEAVE POOL - REQUEST TO USE HOURS**

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The intent of the USF Sick Leave Pool is to help a member who experiences a short-term serious personal disability, illness or injury and who exhausts all personal leave balances, to remain in full pay status for the period of time defined by the Pool procedures.

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Employee Name \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Campus Address \_\_\_\_\_ Ext. \_\_\_\_\_ FTE \_\_\_\_\_

# of Hours Needed \_\_\_\_\_ (up to 320) for period from \_\_\_\_\_ to \_\_\_\_\_

I have used 40 hours of my own leave towards this illness/injury and my accrued leave (annual, sick, compensatory and personal holiday) will be depleted as of \_\_\_\_\_ and the requested hours are needed for my serious injury/illness. I understand that the period of time that I have requested for this medical leave of absence counts towards my entitlement as outlined under the Family Medical Leave Act.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

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I have approved a medical leave of absence for the above referenced employee due to the physician's medical assessment and have verified that the information provided on this form and on all time sheets and leave records is correct. To the best of my knowledge, the employee will have used \_\_\_\_\_ number of leave hours towards this illness/injury once all leave is depleted. I understand that I am not to certify for payment hours from the sick leave pool until authorization is received from the Administrator of the Sick Leave Pool. I have notified the employee that this medical leave of absence is being counted toward his/her entitlement as outlined under the Family Medical Leave Act.

Supervisor's Name (print): \_\_\_\_\_ Campus Address: \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Campus Extension \_\_\_\_\_ Date \_\_\_\_\_

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