FLORIDA A&M UNIVERSITY

SICK LEAVE POOL APPLICATION

NAME: ______________________________ SSN: ________________________

DEPARTMENT: ____________________________ EXT. NO: __________________

CAMPUS ADDRESS: ____

I hereby apply for membership in the University's Sick Leave Pool. I have read and understand the terms and conditions that apply to membership and I agree to follow the procedures established for participation in the Sick Leave Pool. I understand that I am required to make an initial contribution of eight hours* of sick leave and subsequent contributions, if necessary, not to exceed sixteen hours per year.

____
Employee's Signature/Date

*Number of hours required for full-time employees. The required number of hours for part-time employees is prorated based on the employee's F.T. E.

Return to: **University Personnel Relations Office**
Attendance and Leave Section
211 Foote-Hilyer Administration Center
Campus

D O N O T W R I T E B E L O W T H I S L I N E

FOR SICK LEAVE POOL COMMITTEE USE ONLY

Verification of the following information has been provided by the Office of Personnel Relations to establish eligibility in the University's Sick Leave Pool.

Current Sick Leave Balance: __________ as of ______________________________

Employee meets membership eligibility requirements? YES[ ] NO[ ]

Employee FTE: ______ Hours Contributed: ________ Initial Contribution Date: ________

Membership Approval Date: __________________ Denial Date: __________________

Reason for Denial: ____

____

Authorized Signature: ____________________________________
Committee Chairperson or Committee's Designee

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