# JOAQUIN ISD REQUEST FOR SICK LEAVE POOL DAYS

Please complete this form and return to _____. An official **Sick Leave Pool Attending Physician's Statement** must also be submitted before this request can be considered. Sick leave pool days shall be used only for the catastrophic illness or injury of the employee or _____.

---

Date: _____/_____/_____

Employee Name: _____

Address: _____

Telephone:_____Campus/Dept. _____

Patient's name if different than above: _____ Relationship to employee: _____

I have or will have used all my available state and local leave, as well as any compensatory time and vacation days, as applicable.

I am requesting leave: Begin: _____/_____/_____ End: _____/_____/_____

Nature of illness or injury*: _____

_____

_____

Date illness began or accident occurred: _____/_____/_____ Date physician consulted: _____/_____/_____

Name, address, and phone number of attending physician: _____

_____

_____

Did the condition require hospitalization? Yes _____ No _____

If yes, please complete the following information:

Name of hospital: _____

Dates of confinement: Begin: _____/_____/_____ End: _____/_____/_____

**I certify that the information given on this request for sick leave bank days is accurate and true.**

Signature of Employee: _____Date: _____

* **GINA NONDISCLOSURE NOTICE:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**For Administration Office Use Only** *(copy will be sent to employee after completion)*
Date Received: _____

Superintendent Signature—Approved:_____Date:_____
Denied:_____ Date:_____
Pool Days Effective Beginning:: _____