FLORIDA STATE UNIVERSITY
OFFICE OF HUMAN RESOURCES
A6200 University Center
Tallahassee, FL 32306-2410
Phone: (850) 644-5052

FLORIDA STATE UNIVERSITY
SICK LEAVE POOL PHYSICIAN'S REPORT and REQUEST TO USE HOURS

SECTION 1 – TO BE COMPLETED BY EMPLOYEE (Please Print)
By submitting this request you agree to all the terms and conditions for the use of Sick Leave Pool hours as defined in FSU policy.

Name of Employee: _____ Employee ID: _____
(9 digit OMNI number)

Home Mailing Address: _____
Street City State Zip Code

Home/Cell Phone: _____ Email Address: _____

STATEMENT FROM PARTICIPANT EMPLOYEE TO EXAMINING PHYSICIAN

I authorize my physician to release any information requested on this form and any other pertinent information concerning my condition to the FSU Sick Leave Pool Administrator and Committee.

Physician's Name: _____ Physician's Phone: _____

Physician's Address: _____
Street City State Zip Code

Signature of Participant Employee: _____ Date: _____

SECTION 2 – TO BE COMPLETED BY PHYSICIAN (Please Print)
TO ATTENDING PHYSICIAN: This application will be reviewed by the FSU Sick Leave Pool Committee (including a physician from the FSU College of Medicine) for the purpose of determining allowable paid sick leave benefits. Only fully completed applications will be considered. The Sick Leave Pool Committee is authorized to grant up to 160 Sick Leave Pool hours (20 workdays), for requests arising from catastrophic/serious personal illness, accident, or injury or combination of conditions which has a major impact on life-functions. If additional time is needed, the employee must fill out a new request form with physician's documentation. These requests must be filed on a monthly basis until the employee returns to work full time.

Date individual was first examined with this condition: _____

Diagnosis: _____

_____

Treatment Plan (including physical and rehabilitative therapies): _____

_____

Employee can perform the essential function of his/her job: □YES □NO If no, explain any limitations:

_____

_____

Employee may return to work: □ Full Time on (date) _____ or □ Re-evaluated on (date) _____

Physician's Signature _____ Date _____