FLORIDA A&M UNIVERSITY
SICK LEAVE POOL APPLICATION

Name: _____ Employee ID#: _____

Department: _____ Office Phone: _____

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: Office of Human Resources
Benefits and Retirement
211 FHAC
Campus

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FOR SICK LEAVE POOL COMMITTEE USE ONLY

Verification of the following information has been provided by the Office of Human Resources to establish eligibility for membership 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

Revised 10/2018