**OFFICE OF COURT ADMINISTRATION**

**SICK LEAVE POOL APPLICATION**

NAME SSN (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please check one:*

**CONTRIBUTION:** I have verified my sick leave balance and request that hours be deducted from my accrued sick leave and transferred to the State Office of Court Administration Sick Leave Pool.

**WITHDRAWAL FOR CATASTROPHIC ILLNESS OR INJURY:** I have or will have exhausted all my sick leave and extended sick leave on (date) and request hours from the State Office of Court Administration Sick Leave Pool because of a catastrophic illness or injury. (The amount cannot exceed one-third of the balance of hours in the pool or 90 days, whichever is less.)

I have read and understand the State office of Court Administration Sick Leave Pool Policy.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Employee Date*

**RECOMMENDATION OF POOL ADMINISTRATOR:** Amount of time recommended by the Pool Administrator to be granted from the Sick Leave Pool for a catastrophic injury or illness is hours, which is certified to be less than one-third of the hours in the pool or 90 days, whichever is less.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Pool Administrator Date*

**APPROVED**:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Administrative Director Date*

**PERSONNEL:** *Upon approval distribute copies to*:

 *Employee*

 *Employee’s Division Director*

 *Payroll Officer*