

**Texas A&M University – Commerce  
Sick Leave Pool**

1 of 2

**Withdrawal Request Form**

Date of Request: \_\_\_\_\_

Name: \_\_\_\_\_

UIN: \_\_\_\_\_

Department: \_\_\_\_\_

I request that \_\_\_\_\_ hours be granted to me from the Sick Leave Pool. These hours are requested from \_\_\_\_\_ to \_\_\_\_\_ on \_\_\_\_\_ to \_\_\_\_\_.  
(Time) (Time) (Mo., Day, Yr) (Mo., Day, Yr)

**Reason for Request: (check all that apply)**

\_\_\_\_\_ Catastrophic illness or injury. Describe:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Is illness or injury for yourself or immediate family member?  
\_\_\_\_\_

If for family member:

What is the relationship of the family member?  
\_\_\_\_\_

Does the immediate family member live in the same household as you?  
\_\_\_\_\_

Is the immediate family member totally (no one else to care for the individual) dependent upon you for personal care or services?

Yes \_\_\_\_\_ No \_\_\_\_\_

If the immediate family member is totally dependent upon you for personal care or services, is this dependency on a continuing basis?

Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

**Withdrawal Request Form 2 of 2**

\_\_\_\_\_ Re-instatement of prior contribution to Sick Leave Pool. Request based on non-catastrophic illness or injury and exhaustion of accrued sick and annual leave.

**I understand that all requested information must be furnished, and the physician's certification of the illness, including the diagnosis, prognosis, and expected recovery date must be attached before this request will be considered for approval. I also understand that if the request is for an immediate family member, the doctor must certify that the family member needs continual care for a specific period of time.**

\_\_\_\_\_  
Employee (or Designee) Signature

\_\_\_\_\_  
Date

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**For Administrative Use Only:**

I certify that this employee:

\_\_\_\_\_ has exhausted (or will exhaust) all earned sick and annual leave as of \_\_\_\_\_.

\_\_\_\_\_ has contributed \_\_\_\_\_ hours to the Sick Leave Pool.

\_\_\_\_\_ has provided doctor's certification of the illness, along with the prognosis, and expected recovery date.

\_\_\_\_\_ has provided doctor's certification of need for continual care, if for family member.

**Requested \_\_\_\_\_ Hours**

**Approved for \_\_\_\_\_ Hours**

**Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_**

**Denied \_\_\_\_\_ Reason: \_\_\_\_\_**

\_\_\_\_\_  
FMLA/Leave Coordinator