



# SONORA INDEPENDENT SCHOOL DISTRICT

807 SOUTH CONCHO \* SONORA, TEXAS 76950  
325/387-6940 \* FAX: 325/387-5090

Sonora Independent School District has a Catastrophic Sick Leave Pool to provide a potential source of sick leave for those employees who have experienced a catastrophic illness or injury. "Catastrophic illness or injury" shall mean life-threatening illness or disability requiring medical treatment or medical care of an employee or a member of the employee's immediate family and;

- Requires the services of a licensed physician
- Causes the employee to exhaust all state and local sick leave, personal leave and vacation days, if applicable.

## Part I. Employee Information

Employee Name: \_\_\_\_\_ ID # \_\_\_\_\_

Home Address: \_\_\_\_\_  
Number City State Zip

Home Phone: \_\_\_\_\_ Campus \_\_\_\_\_

## Part II. Request for Establishment of Sick Leave Pool

I request establishment of a sick leave pool on behalf of (check one) \_\_\_ myself or \_\_\_ an immediate family member because of catastrophic illness or injury.

I understand that voluntary contributions by District Staff on my behalf may only consist of a maximum number of **30** local sick days total. (*Extraordinary circumstances subject to review by Administration*)

I understand that my sick leave pool shall cease to exist when I return to work or if the **30** (number) of local sick days in the pool has been exhausted.

If the request is because of an illness or injury of an immediate family member, please provide:

1. The name of the ill/injured individual: \_\_\_\_\_ and
2. The relationship to the employee: \_\_\_\_\_

**Part III Verifications**

I understand that I must meet the requirements set out in the Sick Leave Pool Policy to be eligible to establish sick leave pool. I understand that the decision of the Superintendent or designee concerning my request for establishment of sick leave pool is final. I understand that I must authorize my licensed practitioner to release the information requested on the Licensed Practitioner Statement form, and other necessary information, to the Superintendent or designee. I understand that I authorize Superintendent to release what medical information is necessary in order to request voluntary donations from District Staff on my behalf.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Part IV to be completed by Payroll Department**

1. Employee's last day worked: \_\_\_\_\_
2. Has the employee exhausted all sick leave due to the condition for which they are applying for establishment of Sick Leave Pool? \_\_\_\_\_ Date: \_\_\_\_\_
3. Has the employee exhausted, or is likely to exhaust vacation time or compensatory time, due to the condition for which they are applying to establish sick leave pool? \_\_\_\_\_
4. Indicate the date the employee exhausted, or is likely to exhaust all accrued and available leave balances \_\_\_\_\_.

**Part V Sick Leave Pool Administrator**

Date completed application reviewed: \_\_\_\_\_

Eligibility for Sick Leave Pool Establishment met: \_\_\_\_\_ Yes \_\_\_\_\_ No

Approval Signature: \_\_\_\_\_

Date: \_\_\_\_\_