SICK LEAVE POOL
APPLICATION FOR MEMBERSHIP AND AGREEMENT

Name	Continuous Service Date	People First ID #
Office	Email Address	Phone #

I have been employed by the State of Florida for one (1) continuous year, have a minimum sick leave balance of sixty-four (64) hours and request membership in the COM Sick Leave Pool. My signature below indicates that I understand and agree to the following:

1. **I agree** to donate eight (8) hours (prorated if part time), of my personal sick leave to the COM Sick Leave Pool for initial membership.

2. **I agree** to have eight (8) hours (prorated if part time) of sick leave automatically transferred from my sick leave pool account to the COM Pool any time the balance of the Pool falls below the minimum required balance as determined by the Sick Leave Pool Committee. If I have less than the required hours at that time, I will contribute all sick leave hours I have accumulated and will contribute the remainder as soon as it is accrued. I realize that I will not be allowed to use my sick leave credits until the amount owed to the Pool has been contributed.

3. **I understand** that, if I fail to have a sufficient balance in my sick leave account when requested to make a contribution, my sick leave usage shall be investigated by the Sick Leave Pool Administrator for determination as to whether my membership in the Pool should be cancelled. I understand that the decision for cancellation will be made by the Sick Leave Pool Committee and I agree to abide by that decision.

4. **I understand** I am entitled to withdraw up to a maximum (lifetime total) of five hundred twenty-eight (528) hours (prorated if part time), to be used for extended absences due to personal illness, accident or injury after depletion of all my personal annual, sick and compensatory leave.

5. **I understand** any leave I contribute to the Pool will be forfeited if I cancel membership or separate from state government.

6. **I understand** any alleged abuse or misuse of the Sick Leave Pool by me will be investigated and if warranted, I will repay all sick leave credits withdrawn from the Pool, will have my membership cancelled and will be subject to disciplinary action.

7. **I understand** my Pool membership must be in effect for a period of at least six (6) months prior to my being eligible to withdraw leave from the Pool.

Signature of Applicant		**Date**
Below To Be Completed by Pool Administrator		
Action Taken ☐ Approved ☐ Disapproved	**Signature**	**Date**