COVID-19 Sick Leave Pool Request Form

Name:____ UofSCID: _________________________

Department:____________________________________

This form is to be completed by employees who have:

- **tested positive for COVID-19 or have an immediate family member who has tested positive for COVID-19**
  AND
- **exhausted all available annual, sick, and (if applicable) Emergency Paid Sick Leave**

Have you or an immediate family member tested positive for COVID-19?
Required: *Submit positive test result with your form.* Yes ☐ No ☐

Have you exhausted all available leave?
(*Sick Leave, Annual Leave, Comp Time*) Yes ☐ No ☐

Start Date of Leave:______________________

End Date of Leave (*Actual or Projected Date*):____________________

Total Number of Hours Requested:_____________________
(Calculation: *Number of Days x Scheduled Number of Hours per Day*)

Please provide a brief explanation as to why you do not have sufficient leave available to cover this absence.

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I understand that if my request is approved, I am subject to the terms of the university's Leave Transfer Pool and that any unused leave will be returned to the appropriate Leave Transfer Pool.

Employee Signature:_____________________________________ Date:_______________

TO BE COMPLETED BY THE DEPARTMENT: Approved ☐ Denied ☐

Comments/Reason for Denial:____

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Department Head Signature:____ Date:_______________

TO BE COMPLETED BY THE OFFICE OF HUMAN RESOURCES: Approved ☐ Denied ☐

Comments/Reason for Denial:____

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Authorized HR Signature:____ Date: _______________

Return completed form with required documentation to hrfmla@mailbox.sc.edu