Administrative Management Guidelines

SICK LEAVE POOL

The District sick leave pool shall be established by voluntary donations from District staff of local sick leave days for the purpose of assisting a fellow employee who has a catastrophic illness or disability. The plan can also be established for the employee who has an immediate family member with a catastrophic illness or disability, such as:

1. Spouse.

2. Son or daughter, including a biological, adopted, or foster child, a stepchild, a legal ward, or a child for whom the employee stands *in loco* parentis.

3. Parent, stepparent, or other individual who stands *in loco parentis* to the employee.

The employee may participate in the pool until he or she has used a maximum of 50 days from the pool and **will cease upon returning to work**.

ESTABLISHMENT

A request for the establishment of a sick leave pool shall be made by submitting a request to the Human Resources Office for a Sick Leave Pool packet **at the time the employee is on medical leave**. To qualify for a pool, the employee must first have exhausted all paid leave (ie, local, state, and paid vacation days if applicable.). A request must be made before pool days are contributed. A family member may request pool days by submitting the following information:

1. Exhibit A signed by the member requesting pool days and stating conditions which necessitate the request.
2. A physician's report stating the catastrophic illness or injury.
3. Dates of absences from work for catastrophic illness or injury.
4. The number of days requested.

If an employee is critically ill and unable to file a request for pool days, the school principal, immediate supervisor or department head may initiate the request at the request of the employee or a family member. **The request for sick leave pool shall be posted by the employee's supervisor at the work site.** If enough days cannot be generated from the home campus/location, district employees may be notified of the request for donated days by posting at other sites.

RESTRICTIONS

The sick leave plan shall be created from voluntary contributions by District staff for a specific individual (Exhibit B). Contributions may consist of one to three local sick leave days per donor. Staff members may not contribute more than three leave days to the plan per school year. The days must be contributed in half or whole days. Only earned local sick leave days may be contributed to the sick leave pool. These days will be subtracted from the employee's local sick leave balance. A "day" granted to an employee shall be equivalent to the number of hours in that typical workday. The employee who has a catastrophic illness or disability shall be paid at his or her daily rate.

CESSATION OF PLAN

The sick leave pool shall cease to exist when the employee returns to work, or if the employee terminates employment, or when each voluntary donation reaches the three day maximum contribution and/or the sick leave pool is exhausted with a maximum of 50 total days donated.

LIMITATIONS

Catastrophic illness is defined as an extended **life-threatening** critical illness. It requires the services of a licensed medical practitioner for a period of time and an extended absence from work **for more than 50 days** for treatment or recovery where the absence extends after the employee has exhausted all accumulated state and local leave, personal leave, additional sick leave with salary deductions, and vacation days.

Use of the extended sick leave pool shall run concurrently with the Family Medical Leave Act.

McAllen Independent School District
Request For Sick Leave Pool Form
Exhibit A

NAME OF EMPLOYEE: _____ **EID#**: _____

School/Department: _____ **Assignment**: _____

Date of Request: _____ **Number of days requested:** _____

I have (or will have) used all my available sick leave days for this year.

* Do you anticipate any additional days to be needed for follow-up examination or treatment?
  _____ Y _____N

***** Have you made claim or are you entitled to Worker's Compensation Benefits?
  _____Y _____N

The above requested days are needed for the reason of personal or family illness as described in the attached statement from my attending physician (or on the physician's letterhead stationary).

Information to be included in the doctor's statement:

***** Identification and nature of illness and/or extent of injury. (An explanation in laymen's language is preferred).
***** Anticipated date eligible to return to work.
***** Anticipated days, if any, for follow-up examination or treatment.

The doctor's statement is attached. _____ Yes _____ No

	Illness	**Accident**
When did symptoms begin?	_____	_____
When was doctor consulted?	_____	_____
Name of Physician(s):	_____	
Address of Physician(s):	_____	
Phone number(s) of Physician(s):	_____	

I hereby verify that the information given is valid to the best of my knowledge and I authorize release of my medical records to the Superintendent or designee.

_____ _____

Date Employee's Signature (or Designee, if necessary)