Julie K Morton **Brewster County Treasurer**
107 W Ave E- #4
Alpine, TX 79830
Ph: 432-837-6200
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county.treasurer@co.brewster.tx.us

Sick Leave Pool Application
(Withdrawal)

Employee's Statement

1. Name:_____
2. Department: _____ Supervisor: _____
3. If request is for the disability of a dependent, please complete:
   Dependents Name: _____Relationship to Employee: _____
   Does dependent reside in your household? Yes ____ No____
4. Last day physically at work: _____
   Expected Return Date: _____
5. Accrued Leave Available at the commencement of absence:
   Sick Leave _____ Vacation _____ Total _____
6. Number of hours you are requesting from the sick leave pool: _____

I certify that the above answers are true and correct to the best of my knowledge and authorize any doctor or medical institution having information concerning my illness to release information to Brewster County concerning this application.

I certify that I am unable to work due to a severe condition affecting the mental or physical health of me or my immediate family.

Signature of employee: _____ Date: _____

Treasurer's Office Use Only

Received by: _____ Date:_____

Application Approval: Yes_____ No: _____ Hours Awarded: _____

Signature, Sick Leave Pool Administrator: _____

Date: _____

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Certification of Physician or Practitioner

1. Employees Name: _____
2. Patients Name: _____
3. Diagnosis (including complications):_____

   _____

   _____
4. Date conditions commenced:
5. Probably duration of condition:
6. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   Yes_____ No_____ If so, dates of admission:_____
7. Date(s) you treated the patient for condition?_____
8. Is the employee able to perform the functions of the employees position:

   Yes_____ No_____
9. Catastrophic illness or injury is one that prevents an employee from performing the functions of his/her job , a severe condition or combination of conditions affecting the mental or physical health of the employee or the employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time.

   In your opinion, do the circumstances of this case meet the definition?

   Yes _____ No_____

   Name of Attending Physician:_____

   Address:_____

   Telephone number:_____

   Signature:_____ Date:_____

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