UNIVERSITY OF
South Carolina

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 for which the employee's direct care is required**
  AND
- **exhausted all available annual and sick leave.**

Have you or an immediate family member tested positive for COVID-19? Yes ☐ No ☐

Required: ***Submit positive test result with your form.*** Yes ☐ No ☐

If your immediate family member has tested positive for COVID-19, is your direct care required? Yes ☐ No ☐

Direct care occurs when an employee is the primary caretaker of an immediate family member in isolation due to a positive COVID-19 test result.

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.

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: _____

_____

Department Head Signature: _____ Date: _____

TO BY COMCOMPLETED BY THE OFFICE OF HUMAN RESOURCES: Approved ☐ Denied ☐

Comments/Reason for Denial: _____

_____

Authorized HR Signature: _____ Date: _____

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