REQUEST FOR POOL LEAVE

This form is to make application for the use of paid leave time from the Hardin County Sick Leave Pool.

Please submit one original to the Human Resources Director and a copy to your supervisor.

SECTION I: TO BE COMPLETED BY REQUESTING EMPLOYEE

_____ _____ _____
Employee Name (Print) Social Security # Department

Last day employee physically on duty: _____

Date and time employee exhausted all paid leave: _____

Sick Leave Pool time requested: _____

Leave without pay: From: _____ to: _____

The requested must be accompanied by a Certificate of Illness/Injury.

Note: You understand that the Certificate of Illness/Injury is protected health information under HIPPA. You understand that any documentation submitted with this form will be shared with the Human Resources Director and the Committee assigned to review these requests. By signing below, you release and hold harmless Hardin County, the Human Resources Director, and the Committee from any legal action in regarding this form and the documents attached. You consent to this form and documents attached being seen/reviewed/discussed by the Human Resources Department and Committee members. All protected healthcare information under HIPPA will only be seen/reviewed/discussed among Committee members.

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

Section II: TO BE COMPLETED BY THE HUMAN RESOURCES DIRECTOR

Request Approved: _____ Request Denied: _____

Amount of Time Approved: _____

_____ _____
Human Resources Director Date

CERTIFICATION OF ILLNESS/INJURY

SECTION I: TO BE COMPLETED BY REQUESTING EMPLOYEE

_____ _____ _____
Employee Name (Print) Social Security # Department

I authorize the named physician or other licensed practitioner to provide medical information about the Employee to Hardin County.

Physician/Practitioner's Name: _____

Address: _____

Telephone Number: _____

_____ _____
Employee Signature Date

SECTION II: TO BE COMPLETED BY PHYSICIAN OR OTHER LICENSED PRACTITIONER

Date of Onset illness or injury: _____

Date employee was first unable to work due to this injury:
_____

If surgery was required, give date: _____

Describe illness/injury (describe surgical procedure, if necessary):
_____
_____
_____
_____

Prognosis:
_____
_____
_____

Date employee is anticipated to return to regular duties:
_____

Restrictions (if any):
_____
_____
_____

Practitioner's Name: _____

Address (street, city, state, zip):
_____

Telephone: _____

_____ _____
Signature, Physician/Other Licensed Practitioner Date

This form must accompany any application with a request for pool leave, and should be submitted to the Hardin County Human Resources Director.

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Check as appropriate

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

_____

_____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal

☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Check as appropriate

☐ a) From_____to _____

Or

☐ b) All past, present, and future periods

Or

☐ c) The date of the signature in section VI until the following event:

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature:_____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____