APPLICATION FOR SICK LEAVE BANK BENEFITS

Applicant's Statement of Illness (Please print or type)

NAME_____

ANY FORMER NAMES (Maiden etc.) _____

ADDRESS_____

HOME PHONE_____ CELL PHONE_____E-MAIL_____

POSITION_____BUILDING_____

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE NUMBER: _____

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ABSENCE BEGINS_____ABSENCE ENDS_____

TOTAL NUMBER OF DAYS REQUESTED AFTER USING 10 CONSECUTIVE DAYS OF SICK LEAVE_____

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I understand that I must apply for all the days I need at this time. These must be contained in this original application. If requesting more than 6 weeks, an updated medical statement will be required. I authorize the Sick Leave Bank Committee to confer with my physician in regards to the number of days required for my recuperation. I also understand that I could be required to obtain a second opinion before the bank will grant days. This cost will be paid by me. I can amend this application but a new doctor's statement will be required and a second opinion may be required at that time.

Also, I understand that the bank will grant four days and I will contribute one day for the duration of the grant. If I do not have sick days or personal days to cover, I will lose pay for that day.

DATE_____

APPLICANTS SIGNATURE_____

RETURN THIS APPLICATION AND THE MEDICAL STATEMENT FORM TO A SICK LEAVE BANK COMMITTEE MEMBER:

Connie Irick - Washington Elementary
Kathy O'Brien - Washington Elementary
Franciena Steinmetz- Alameda Middle School
Whitney Covey - District Office
Diane Hansen - District Office

MEDICAL STATEMENT

DATE_____

EMPLOYEE_____

I hereby authorize the release of any/all medical information related to the treatment I, or my dependent, have received or are now receiving.

SIGNATURE_____

School District No. 25 requests the following information regarding the illness, injury, and/or disability incurred by our employees that required the care of a medical practitioner. This information is needed to determine the number of Sick Leave days needed for the patient to physically recuperate from the illness or injury. If you require more space, please attach additional information or documents. **Any statement that is vague or unclear can result in a denial of the grant.** Please be complete and realistic in regards to the amount of time the applicant needs to refrain from working.

PATIENT NAME_____

DATE FIRST SEEN_____

DATE THE INJURY OR ILLNESS OCCURRED_____

Please explain (layman's terms) the nature of the condition or diagnosis.

_____

_____

_____

_____

Please explain the short or long term effects due to treatment, surgery or medication(s) that we need to know to understand the illness or injury. (Prognosis)

_____

_____

_____

Please explain what continued treatment, therapy or medication(s) have been prescribed or ordered if any.

_____

_____

_____

What is the estimated date you anticipate the patient will be recovered and **able** to return to work?

_____

Physician's Signature_____

Date_____