SICK LEAVE BANK CONTRACT

____ has been ***approved*** for use of _________ days from the Sick Leave Bank. Use of the Sick Leave Bank is contingent upon the following conditions:

1. Personal presentation of physicians' certification of continuing illness on the date, time, and place to be determined by the Committee. (An exception to the above will be accommodated in those instances where the teacher is physically incapacitated, in which case said teacher requesting use of the Sick Leave Bank shall be represented by a person or persons of their choice.)
2. Written statement of anticipated duration of need to the Sick Leave Bank.
3. That said person is not employed during use of Sick Leave Bank.

____________________________ ____

Date Applicant's Signature *[or authorized representative]*

____ has been ***denied*** use of _____ days from the Sick Leave Bank for the following reasons:

____

____

____

____

You have the right to appeal this decision per Section 12. Please follow these instructions if you wish to appeal.

Sick Leave Bank Committee Members:

____ ____

SEA Trustee SEA Trustee

____

Administration Trustee

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I do hereby authorize and direct any licensed practitioner to provide the Sick Leave Bank Trustees any medical information acquired for the purpose of diagnosis and treatment while attending me in a professional capacity.

____ ____

Patient's Name Patient's Signature

____ ____

Social Security Number Date Release Signed

Trustee Assigned____ *10/98*

APPLICATION FORM - SICK LEAVE BANK

Applicant's Name:_______________________________________ Date:____________________________

Address:____ Phone:___________________________

School:___________________________________ Age:_________ No. of Years in District:_____________

Name or description of present illness: ____
____

Total number of accumulated sick days prior to present illness:____________________________________

Date first absent from school due to present illness: ____

Have you received benefits from the Sick Bank previously? _______ When? ________________________

Date you wish to begin drawing from the Sick Leave Bank: ______________________________________

Physician's name: ____

Address:____
____

(Attach two (2) physician's statements ***directly to this form***. You will need to submit a physician's statement at the ***first of every month that you are using the Sick Leave Bank***.)

Approximate date of return to school (if known):____

Have you worked at all, in any capacity, since you became disabled? ___Yes ___No

Do you have any other disability insurance coverage available to you? ___Yes ___No

Are you or will you be employed while on Sick Bank? ___Yes ___No

Are you or will you be participating in a business venture while on Sick Bank? ___Yes ___No

FAILURE TO REPORT OTHER SOURCES OF INCOME WILL RESULT IN TERMINATION OF BENEFITS.

I attest that the above statements are true to the best of my knowledge.

____

Applicant's Signature *[or authorized representative]*

10/98

SPRINGFIELD PUBLIC SCHOOLS - SPRINGFIELD EDUCATION ASSOCIATION

PHYSICIAN'S REPORT OF DISABILITY

(Definition of disability is a generic definition, not a legal definition.)

(please print or type)

1. Name of claimant ______________________________
2. Date claimant disabled ______________________________
3. Dates of treatment ______________________________
4. Was claimant able to continue to work after the disability*?____ How long?__________________
5. Was claimant treated by another physician?____ Name ______________________________
   Address ______________________________
6. Was claimant hospitalized?____ Name of hospital______________________________
   From______________________________ To ______________________________
7. What is the precise nature and extent of disability ______________________________
   ____
   ____
8. Has claimant any chronic or constitutional disease or physical defect or deformity?______________
   What? ______________________________
9. What complications have arisen? ______________________________
10. Have there been any laboratory tests made?____ Results?______________________________

11a. Was surgery performed?____ Briefly describe:______________________________ When?______

11b. Is surgery elective? ____ If yes, is surgery necessary now, or could it be safely performed during summer vacation months?

12. Is claimant now able to resume any portion of teaching duties?_____ Since when?______________
13. What, in your opinion, is the probable duration of this disability?__________________________
14. What is the approximate date when member may be able to resume assigned teaching duties? _____
    In your judgment, could claimant return to teaching duties on a part-time basis? ________________
15. In your judgment, is the claimant incapacitated from duties as a teacher permanently or temporarily?
    ____

I, a practicing physician, registered under the laws of the State of ___________________, my registry number being ___________________, certify my answers to the foregoing questions are complete and true to the best of my knowledge, information, and belief.

Dated ______________________________ Signed ______________________________

Phone Number ______________________ Street Address ______________________________

City, State, Zip ______________________________

10/98

SPRINGFIELD PUBLIC SCHOOLS - SPRINGFIELD EDUCATION ASSOCIATION

PHYSICIAN'S REPORT OF DISABILITY

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(please print or type)

1. Name of claimant ____________________
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   From____________________ To ____________________
7. What is the precise nature and extent of disability ____________________
   ____
   ____
8. Has claimant any chronic or constitutional disease or physical defect or deformity?____________
   What? ____________________
9. What complications have arisen? ____________________
10. Have there been any laboratory tests made?____ Results?____________________

11a. Was surgery performed?____ Briefly describe:____________________ When?______

11b. Is surgery elective? ____ If yes, is surgery necessary now, or could it be safely performed during summer vacation months?

12. Is claimant now able to resume any portion of teaching duties?_____ Since when?____________
13. What, in your opinion, is the probable duration of this disability?____________________
14. What is the approximate date when member may be able to resume assigned teaching duties? _____
    In your judgment, could claimant return to teaching duties on a part-time basis? ____________
15. In your judgment, is the claimant incapacitated from duties as a teacher permanently or temporarily?
    ____

I, a practicing physician, registered under the laws of the State of ____________________, my registry number being ____________________, certify my answers to the foregoing questions are complete and true to the best of my knowledge, information, and belief.

Dated ____________________ Signed ____________________

Phone Number ____________________ Street Address ____________________

City, State, Zip ____________________

10/98

SPRINGFIELD PUBLIC SCHOOLS - SPRINGFIELD EDUCATION ASSOCIATION

PHYSICIAN'S REPORT OF MATERNITY DISABILITY

(Definition of disability is a generic definition, not a legal definition.)
(please print or type)

1. Name of claimant ____________________

2. Date on which claimant was disabled to the extent she could on longer perform her duties as a teacher
____

3. Anticipated date of delivery ____________________

4. Anticipated date the disability will cease and the claimant is able to again engage in gainful employment ____________________

I, a practicing physician, registered under the laws of the State of ____________________, my registry number being ____________________, certify my answers to the foregoing questions are complete and true to the best of my knowledge, information, and belief.

Dated ____________________ Signed ____________________

Phone Number ____________________ Street Address ____________________

City, State, Zip ____________________

Detach & submit Pregnancy Supplemental AFTER the birth of the baby.

PHYSICIAN'S CERTIFICATE - PREGNANCY SUPPLEMENTAL

For: Springfield Education Association - Sick Leave Bank

Re: ____________________

Date: ____________________

1. Indicate the date on which claimant was disabled to the extent she could no longer perform her duties as a teacher ____________________

2. Indicate **EXACT** date of delivery ____________________

3. Was the delivery by Cesarean Section? ____________________

Signed ____________________

Street Address ____________________

City, State, Zip ____________________

FAILURE TO RETURN THIS FORM WITHIN 14 CALENDAR DAYS OF DELIVERY WILL RESULT IN TERMINATION OF BENEFITS UNTIL RECEIPT BY A TRUSTEE.

10/98

STATEMENT OF UNDERSTANDING

Applicant: ____ **Date:** ___________________________

Representative: ___________________________________

Trustee:____

I understand that:

____ I have a lifetime Sick Bank total of ___________ days available to me and that the days I receive will be subtracted from that total.

____ I am responsible for checking with payroll regarding the official date of return from Sick Leave.

____ I have 6 calendar weeks of maternity leave from the date of the birth of my baby (8 weeks for Cesarean).

____ I have 14 days to report the birth of my baby to my trustee or my benefits will be suspended.

____ I must report my return to work to my Trustee and to the Department of Human Services.

____ If I am on Sick Leave when school starts and I have been approved for Sick Bank, the days I receive when I return to work will be returned to the Sick Bank.

____ I can apply for TRS disability for my chronic illness.

____ I must submit a monthly letter from my physician of my continuing inability to work.

____ My benefits will be suspended if I fail to comply with the Sick Bank Bylaws.

____ I have the right to appeal the decision of the Sick Bank Trustees to the SEA Executive Committee..