JEFFERSON COUNTY SCHOOLS

Sick Leave Bank - **REQUEST FORM**

Classified / Non-Instructional Employees

Name _____

Address _____
Street / Box / Apt. No. City Zip

Phone Number _____ Work Site: _____

Request by Employee

All requests to draw from the Sick Leave Bank must be accompanied by a physician's statement on the approved form confirming the cause of illness or injury and must be signed by the physician.

A participant shall not receive any sick leave from the bank until after having exhausted all accumulated sick leave, personal leave and annual leave.

_____ Number of Days Requested from Bank _____
(Date Sick Leave Expired) (20 Day Maximum)

_____ _____
Signature of Employee Date

Committee's Action on Request

TO BE COMPLETED BY COMMITTEE OF TRUSTEES

Request Approved

YES _____ NO _____ _____ _____
Chairperson's Signature Date

Number of Days Approved _____ Effective Dates From _____ to _____

Comments: _____

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Classified / Non-Instructional Employees

PART A – TO BE COMPLETED BY EMPLOYEE

Employee's Name _____

Employee's Address _____
(Street / Box / Apt. No.) City ZIP

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

_____ _____
Signature of Employee Date

PART B – ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and Concurrent Conditions: _____

_____

_____

2. Is the condition due to injury or sickness arising out of patient's employment? YES__ NO__
3. Is the condition due to pregnancy? YES __ NO __
4. Has the condition caused disability of the patient? YES __ NO __
5. Anticipated length of disability? _____
6. Date of disability: From _____ to _____
7. Is the patient able to attend to any full-time work during disability? YES ___ NO ___
8. Date symptoms first appeared or accident happened. _____
9. Date patient first consulted you for this condition? _____
10. Is the patient still under your care for this condition? YES ___ NO ___ If NO, last date seen _____

Physician's Name *(type or print)* _____

Address _____
(Street / Box / Suite) City ZIP

Physician's Signature _____Date _____