

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.

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