APPENDIX H-1 – Sick Leave Bank Request Form

JEFFERSON COUNTY SCHOOLS

Name ____

Address ____

Phone Number _________________________ School ____________________________

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Request

All requests to draw from the 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 and personal leave.

_________________________ Number of Days Requested from Bank ______________
Date Sick Leave Expired (20 Days Maximum)

_______________________________________ ________________________
Signature of Employee Date

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Approval

TO BE COMPLETED BY COMMITTEE OF TRUSTEES

Request Approved

Yes _____ No _____ ______________________________ ________________
Chairperson Date

Number of Days Approved ____________ Effective Dates From _______ To ________

Comments:

Submit Completed Forms to Central Office

PART A - TO BE COMPLETED BY EMPLOYEE

Employee's Name ____

Employee's Address ____

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

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PART B - ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and Concurrent Conditions -

2. Is condition due to injury or sickness arising out of patient employment? Yes ___ No___

3. Is condition due to pregnancy? Yes ____ No ____

4. Has this condition caused disability of patient? Yes ____ No ____

5. Anticipated length of disability? ________________

6. Date of disability: From ____________ To _____________

7. Is 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 patient still under your care for this condition? Yes ____ No ____ If no, date last seen _______________

Physician's Name ____

Address ____

Physician's Signature ___________________________________ Date ____________________