CLASSIFIED PERSONNEL

SICK LEAVE BANK USAGE APPLICATION

Name: _____ Emp # _____

Address: _____

Position : _____ School/Location _____Phone # _____

REASON FOR REQUEST: (Check one)

- ❑ Disabling illness of member or immediate family (policy 03.22321)
- ❑ Injury of member or immediate family (policy 03.22321)
- ❑ Quarantine of member **or** immediate family (policy 03.22321)
- ❑ Other serious, extenuating circumstances normally allowed for sick leaves

NATURE OF ILLNESS OR INJURY - Please provide specific information for this request.

_____

_____

_____

****

You must attach a detailed statement from your attending physician stating the nature of the illness and the date that your physician anticipates releasing you to return to work. If this request is due to an illness of a family member, please provide the same documentation.

****

I am requesting ____ days from the Warren County Board of Education's Classified Personnel Sick Leave Bank. I have used all of my accumulated sick leave, personal days and annual leave. I have been absent from work due to the conditions stated above since _____ (date). I anticipate returning to work on _____.

Employee Signature _____ Date _____

****

CENTRAL OFFICE USE ONLY Date Received at Central Office _____

The employee's anticipated leave was exhausted on _____, (6 deduct days will be from _____ to _____) therefore, sick days from Classified Sick Leave Bank are to begin on _____.

DECISION OF SICK LEAVE BANK TRUSTEES

❑ Approved Number of Days _____ Beginning Date _____

❑ Denied Reason _____

_____, Trustee Chair Date _____

_____, Trustee Date _____

_____, Trustee Date _____

CLASSIFIED PERSONNEL

SICK LEAVE BANK MEDICAL CERTIFICATE FORM

****Sick Leave Bank days may be granted only for instances of disability illness, injury, or quarantine of the individual member of the member's immediate family as defined by policy 03.22321. Grants of sick leave from the Sick Leave Bank shall not be made to any member for the purpose of undergoing elective surgery or during any period the member is receiving disability benefits from Social Security of the County Employees Retirement Plan.****

Name of Patient: _____

Name of Physician: _____

Physician's Specialty: _____

Office Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date patient needs to be (or was) confined to hospital, other medical facility or home:
Anticipated beginning: _____ Ending: _____

Type of illness or injury: _____

1) In your medical opinion, does this illness/injury prevent the employee from performing his/her regular duties? _____

2) In your medical opinion, are there any job duties the patient could perform?
_____

3) How long has this patient been under your care? _____

4) Do you see this patient on a regularly scheduled basis? _____

5) In your medical opinion, when is the patient expected to return to work? _____

6) Is there any other information you can share with the Sick Leave Bank committee that would assist us in making a determination for this request? _____
_____
_____

I hereby certify that it is/was medically necessary for the above patient to be confined to hospital, other medical facility or home as stated above.

Physician's Signature _____ Date _____

(Original physician's signature only - no stamps)

Attach this form to the Sick Leave Bank Usage Application and return it to the Secretary in Instructional Services located at the Central Office.

Revised: 3-23-04