Sick Leave Bank Request Form

Cecil County Public Schools
201 Booth Street , Elkton, MD 21921
Phone: 410-996-5413

Instructions: Complete Employee Section – Have Physician Complete Statement – Return <u>original</u> to Benefits Office

Family Medical Leave will run concurrently with Sick Leave Bank grants.

Employee Information

Name: _____
Last First Initial

_____
Employee's Address

_____
City/Town State Zip

First consecutive day of absence *(for this illness)*:_____/_____/_____

Is this absence due to a work related injury/illness? ___Yes ___No

Employment Status: *(Check all that apply)*

___ Teacher ___ A&S ___Support Service	___ 10-month ___ 12-month	___ Part-time *(less than 30 hrs/wk)* ___ Full-time *(more than30 hrs/wk)*

Job Title: _____

Social Security #: _____ -_____ - _____

Home Phone #: _____-_____-_____

Employee Location: _____ Sick Leave Balance: _____

Previous Bank Usage: ____ Yes ____ No If yes, Number of Days: _____

Employee Authorization to Release Information

I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment. I also authorize information contained herein to be forwarded to the physician(s) designated by the Sick Leave Bank Committee, if required.

X _____ _____
Signature of Applicant /Employee ***Date***

Physician Statement

To be completed by Physician (attach additional information if necessary)

The information you provide may allow this patient to use days donated by other CCPS employees, therefore we ask you to please provide the most accurate and complete information to help the committee promote fairness in granting days.

This is to certify that this patient is under my care and I have examined the above patient on _____ and it is my medical opinion, based on the medical condition and the type of work the patient performs, this patient is:

☐ ***<u>not</u>*** *physically or mentally* ***<u>incapacitated</u>*** *for performance of duty and may return to work without restrictions*

☐ ***<u>totally</u>*** *physically or mentally* ***<u>incapacitated</u>*** *for performance of duty from ____/____/200___ to ___/___/200___*

☐ ***<u>partially</u>*** *physically or mentally* ***<u>incapacitated</u>*** *from _____/_____/200____ to ____/_____/200____* ***and*** *is able to perform their job duties with the following limitations:*

_____

_____

Diagnosis *(extent of incapacity <u>in laymen's terms</u>)*: _____

Treatment:: _____

Prognosis: *(if expected date of return is unknown, show the soonest possible anticipated date)*:_____

_____ _____
Physician's Name (Please Print) **Physician's Address**

_____ _____
Physician's Phone Number: **City/Town** **State** **Zip**

X _____ _____
Physician's Signature (No Stamps Accepted) ***Date***

Committee Use Only

To be Returned within 15 Work days

*Request ___Approved ___Denied # of Days Approved: ____ From ____/____/200___ To ____/____/200___ -or- ____ # days needed for disability period**

*(*For maternity, the typical post-partum disability period granted following a normal delivery is 6 week.)*

Sick Leave Bank Rule # _____ Applied Days Unpaid: _____ ____ Due to 30 day rule ____ Due to waiting period

☐ *Submit another request If additional days are needed.* ☐ *The committee needs additional information for further consideration.*

Comments: _____

Authorized Signature **X** _____ *Date Of Meeting* _____

Distribution: ____ Employee *(w/out med info):* ____Payroll ____Personnel File ____Principal/Supervisor ____SLB Members

Distribution: ____ Employee *(w/out med info):* ____Payroll ____Personnel File ____Principal/Supervisor ____SLB Members