NICHOLAS COUNTY BOARD OF EDUCATION

SICK/DONATION LEAVE BANK

Request for Withdrawal of Days

Please make application, if possible, two weeks prior to the date when you're sick leave expires.

Name_____ Date _____

Address _____

_____

School/Job Assignment_____

Employee ID Number _____

Telephone _____

Please select which bank you are applying for assistance _____ Sick _____ Donation

I hereby apply for the withdrawal of _____ days from the Nicholas County Board of Education Sick Leave Bank. On _____, my accumulated sick leave will be exhausted, and on _____, I will have gone five days without pay.

I authorize to Board of Trustees of the Sick Leave Bank to inspect my sick leave record during my term of employment.

I understand that days borrowed from the bank will be repaid at the rate of (2) days per year until all days over and above those I have donated are repaid.

I am applying for the following reasons:

_____

_____

_____

_____

_____ _____

Signed Date

Please attach the physician's statement which documents your request.

Nicholas County Board of Education
Sick/Donation Leave Bank

Physician's Statement
(To be completed by physician)

I hereby certify that (Patient's name) _____

Please describe medical injury or illness:

_____

_____

_____

_____

The approximate date patient will be considered able to return to work is _____.

In your professional opinion, does this employee have the ability to complete their work related duties as a result of this injury? _____ yes _____ no

Does this injury met the below definition of catastrophic injury? _____ yes _____ no

Catastrophic Medical Injury: Means a medical or physical condition that: (a) incapacitates an employee or an immediate family member for whom the employee will provide care; (b) is likely to require the prolonged absence of the employee for at least twenty or more total working days and (c) will result in substantial loss of income to the employee due to exhaustion of all accrued sick leave, or ineligibility to receive sick leave, including exhaustion of sick leave from the Sick Leave Bank

Attending Physician _____

Address _____

_____

Telephone Number _____

_____ _____

Physician Signature Date