SHERIDAN PUBLIC SCHOOLS

400 N. Rock Sheridan, AR 72150 870-942-3135

REQUEST FOR EMPLOYEE SICK LEAVE BANK BENEFITS

(COMPLETE AND RETURN TO KATYMILLER)

_____ CERTIFIED PERSONNEL _____ CLASSIFIED PERSONNEL

Name: _____

Employee No. _____

Address: _____

_____

Phone Number: _____

Date ALL leave exhausted (verify with payroll):_____

Date of initial Sick Leave Bank use: _____

Total Number of Days Requesting from Bank _____

Please have your doctor complete the attached form and submit it along with your request.

I hereby certify that everything in this application is true and accurate to the best of my ability. I have read the employee sick leave bank policy in the Personnel Policy Manual and accept its provisions. Abuse of sick leave will be sufficient reason for non-renewal of contract.

I understand that a committee of my peers will review my request including medical information.

I hereby give my permission to release information to the review committee for their consideration.

_____

Employee Signature

OFFICE USE ONLY

Date Submitted: _____/_____/_____

Number of days available: _____ Number of days granted: _____

Committee Chair: _____ Date: _____/_____/_____

Dear Doctor _____

Your patient _____ has applied for sick leave benefits from the Sheridan Schools' Sick Leave Bank.

In order for us to consider that request we need the following information:

Please describe the nature of the medical problem:

_____

_____

_____

_____

- If the patient requires surgery:

Is the surgery elective or cosmetic? ___ yes ___ no

Is the surgery required at this time or could it be delayed?
___ required now ___ could be delayed

What is the estimated time the employee will need to miss work? _____

----------OR----------

- If the patient is ill and requires treatment, rest and/or rehabilitation:

Is it necessary that the patient miss work? ___ yes ___ no

Can the patient return to light duty work? ___ yes ___ no If yes, how long? _____

What is the estimated time for recovery _____

I hereby grant permission for release of this information.

_____ _____
Patient's Signature Date

I hereby attest that the information above is accurate.

_____ _____
Physicians Signature Date

_____
Physicians Printed Name

_____
Physicians Address

_____
Physicians Phone Number