SHERIDAN PUBLIC SCHOOLS

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

REQUEST FOR FAMILY SICK LEAVE BANK BENEFITS

(Complete and return to Katy Miller)

_____ CERTIFIED PERSONNEL _____ CLASSIFIED PERSONNEL

Name: ____

Employee No. __________________________________

Address: ____

____

Phone Number: ____________________________________

Date ALL leave exhausted (verify with payroll) _________________________________

Relationship of family member: ____

Total Number of Days Requesting from Bank: ______________________________________

Nature of family member's illness or disability:

____

____

I hereby certify that everything in this application is true and accurate to the best of my knowledge. I have read the employee family 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 ____________________________

A family member of your patient ___________________________ has applied for sick leave benefits from the Sheridan Schools' Family 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 for recovery from surgery? __________________________________

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

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

Is it necessary that the employee miss work to care for the patient? ___ yes ___ no

If yes, how long? ____

I hereby grant permission for release of this information.

__________________________ ___________
Patient's Signature Date

__________________________ ___________
Employee Signature Date

I hereby attest that the information above is accurate.

_________________________ ___________
Physicians Signature Date

____
Physicians Printed Name

____
Physicians Address

____
Physicians Phone Number