Howard County Education Association

CONFIDENTIAL

SICK LEAVE BANK REQUEST
HOWARD COUNTY EDUCATION ASSOCATION

Dorsey Hall Professional Park
5082 Dorsey Hall Drive, Suite 102
Ellicott City, MD 21042
Phone (410) 997-3440 – Fax (410) 997-3443

All items must be completed and forms must be received by the HCEA-HCPSS Sick Leave Bank Committee within 30 calendar days of the first day of the bank usage requested. The applicant's personal days, as well as sick leave days, must be exhausted before sick leave bank usage begins.

(Please print or type)

NAME _____
Last First M Employee ID#

ADDRESS _____
Number City State Zip Home Phone

POSITION _____ SCHOOL/WORK SITE LOCATION _____

Are you receiving a second income? ____YES ___NO
(This will not automatically disqualify an applicant, but it will be weighed in.)

How many hours work per day at HCPSS? _____ If you have a 2nd job, what are the hours?_____

Was this illness/accident work related? _____YES _____NO

How many previous requests have you made for sick leave bank? _____ Dates_____

Reason for your request? _____

Number of days requested from the bank _____ (20 days maximum per request). The Committee reserves the right to waive the 20 days maximum in case of prolonged illness, in conjunction with BOD review/approval.

Specific dates of days required _____. (You are responsible for knowing when your regular sick and personal days have been exhausted.)

I understand that if I am granted leave from the sick leave bank, when I return to work, I will have no sick or personal leave days of my own for the remainder of the school year.

_____
Signature of Application and Date

DATE REVIEWED _____ DATE LAST COVERED BY EARNED SICK LEAVE _____
DUTY DAYS TO BE COVERED BY THIS REQUEST: FROM _____THRU _____
ABSENSE VERIFIED _____ YES ____ NO REQUEST APPROVED ___ YES ____ NO
COMMENTS OR SPECIFIC INSTRUCTIONS _____

_____

_____
Chairperson Date

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Medical Doctor's Statement

TO BE COMPLETED BY PATIENT

Patient's Name and Address: Position:

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned licensed medical doctor to release any information acquired in the course of my treatment or examination. If detailed information is not provided, I understand that it may be necessary to submit more medical statements at the Committee's request. I understand that failure to submit sufficient information may result in denial of this request.

APPLICANT'S SIGNATURE & DATE

TO BE COMPLETED BY LICENSCED MEDICAL DOCTOR

NOTE TO PHYSICIAN: The purpose of this application is to provide sick leave to the above mention member of the HCEA-HCPSS Sick Leave Bank in case of a **prolonged, incapacitating and catastrophic personal illness**. The Sick Leave Bank is a contribution of days from its members (i.e. educators). In order to protect all members of the Sick Leave Bank, it is necessary for the Committee to have specific information if you consider the patient's disability to be **catastrophic.** This will allow the committee to render a fair and reasonable decision whether or not this meets criteria as defined "herein".

PATIENT _____WAS UNDER MY CARE AND UNABLE TO WORK
FROM _____THROUGH _____

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN: (IF EXACT DATE IS NOT KNOWN, GIVE AN APPROXIMATE DATE) _____

Please provide, IN LAYMAN'S LANGUAGE, DETAILED INFORMATION explaining why the patient is unable to perform his/her duties. Please include a brief description of ILLNESS, MEDICAL TREATMENT PLAN, AND CURRENT CONDITION. This information will allow the Committee to render a fair and reasonable decision regarding eligibility.

Licensed Medical Doctor's Name (type or print)

Licensed Medical Doctor's Signature

Address City State Zip

*** Please return this form to patient for submission to Sick Leave Bank Committee.**

Revised: 9/14