Howard County
Education Association

CONFIDENTIAL

SICK LEAVE BANK REQUEST
HOWARD COUNTY EDUCATION ASSOCIATION

Dorsey Hall Professional Park
5082 Dorsey Hall Drive , Suite 102
Ellicott City, Maryland 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 _____ MD _____ Zip _____ Home Phone

POSITION_____ SCHOOL OR CENTRAL OFFICE LOCATION_____

Was this illness/accident work related?_____yes_____no

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

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.

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 Applicant and Date

_____

DATE REVIEWED_____DATE LAST COVERED BY EARNED SICK LEAVE_____
DUTY DAYS TO BE COVERED BY THIS REQUEST: FROM_____THRU_____
ABSENCE VERIFIED_____YES_____NO REQUEST APPROVED_____YES_____NO
NUMBER OF DAYS APPROVED_____

COMMENTS OR SPECIFIC INSTRUCTIONS_____

_____

_____
Chairperson Date

_____

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Medical Doctor's Statement

Howard County Education Association

TO BE COMPLETED BY PATIENT

Patient's Name and Address:

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 LICENSED MEDICAL DOCTOR

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, AND CURRENT CONDITION. This information will allow the Committee to render a fair and reasonable decision regarding this catastrophic illness.

Licensed Medical Doctor's Name (type or print) Telephone

Licensed Medical Doctor's Signature Date

Address City State Zip

NOTE TO PHYSICIAN: **The purpose of this application is to provide sick leave to the above mentioned member of the HCEA-HCPPS Sick Leave Bank in case of a prolonged, incapacitating, catastrophic personal illness. The Sick Leave Bank is a contribution of days from its members (teachers, counselors, etc.) 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.**

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