HCEA Sick Leave Bank Request

Howard County Education Association (HCEA)
5082 Dorsey Hall Drive ● Suite 102 ● Ellicott City, Maryland 21042
Telephone 410-997-3440 ● Fax 410-997-3443

INSTRUCTIONS: Attach Sick Leave Bank Physician's statement (2 pages) and forward all copies to HCEA.

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Check one (√): ☐ **ESP** ☐**Certificated**

Please **PRINT** all information

Check one (√): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Employee ID Number _________________________

Last ____ First ____ MI ________

Address: ____ City ____________________________ State ______ Zip ___________

Home Phone ____ Cell Phone ____

Non-Work Email ____

School/Department ____ School Phone _______________________________

Position ____

Employment Status: Check one (√): ☐10-month ☐11-month ☐12-month

Check one (√): ☐Full-time ☐Part-time If Part-time, hours worked per day _____________ days per week __________

Reason for this sick leave bank request ____

Type of Grant: ☐ **Initial** Grant Request ☐ Grant **Extension** Request Was this illness/injury work related? ☐ Yes ☐ No

At this time have you applied for Disability from the State Retirement System for this condition? ☐ Yes ☐ No

If yes, date and status of application____

Number of days or hours requested from the bank _________ (20 days maximum 1st year, 40 days maximum thereafter. See SLB Policies)

Specific dates of days required ______________________________ *Dates must fall within what your treating physician indicates. You are responsible for knowing when your regular sick and personal days have been exhausted. *HCEA will not calculate these dates for you*.

Have you received previous sick leave bank grants? ☐ Yes ☐ No If yes, how many? _______ Dates _________________________

If any portion of my application is falsified, it may result in disqualification for Sick Leave Bank grants and/or disciplinary action by my employer. By submitting this form I certify that I have reviewed and that I am in compliance with all policies and procedures for Sick Leave Bank including disclosure of any secondary employment. Applicant should feel free to attach any relevant and/or necessary explanations to this application.

____ ____________________________________

Signature of Applicant Date

FOR SICK LEAVE BANK COMMITTEE USE ONLY

SLB Committee Approval? ☐ Yes ☐ No ☐ On Hold # of days approved: ______ Dates Approved: _________________

Comments ____

____

____

Chairperson Signature ____ Date: ______ / ______ / ______

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Physician's Statement Form ● Page 1

THIS SECTION TO BE COMPLETED BY PATIENT

Patient's Name: Last ____________________________________ First ____________________________ MI ____

Address ____________________________________ City ______________________ State ________ Zip ____________

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 clarification is necessary I understand that it may be necessary to submit more medical statements at the Committee's request or I hereby authorize the Sick Leave Bank Administrator to speak directly to the doctor's office. I agree to provide the job analysis found at HCEANEA.ORG to the physician completing this form.

____ __________________________________
Applicant's Signature Date

THIS SECTION TO BE COMPLETED BY *TREATING* PHYSICIAN

NOTE TO PHYSICIAN: The purpose of this application is to provide sick leave to the above mentioned member of the HCEA-HCPSS Sick Leave Bank in case of a prolonged, incapacitating and catastrophic personal illness. This information is necessary to allow the committee to render a fair and reasonable decision whether or not this medical condition meets the criteria of the Sick Leave Bank. Both Physician Statement pages need to be completed.

Patient (name) ____ was under my care and unable to

work from ______ / ______ / ______ through ______ / ______ / ______. (**Dates must be completed**)

Is this patient's condition a permanent disability? ☐ Yes ☐ No If yes, date known __________________________

Was surgery performed or is it scheduled to be performed? ☐ Yes ☐ No

If yes, the following 3 items ***must*** be completed:

- Surgery date __________________________
- Is/Was the surgery: Check one (√) ☐ Elective ***or*** ☐ Non-Elective
- Is/Was the surgery: Check one (√) ☐ Medically necessary at this time ***or*** ☐ Able to wait until school is not in session/system break

____
Licensed Medical Doctor's Signature

____
Licensed Medical Doctor's Name (type or print – MUST be legible)

THIS PAGE TO BE COMPLETED BY *TREATING* PHYSICIAN

Please provide a complete statement of the medical diagnosis confirming the catastrophic and incapacitating nature of the condition. If it appears likely that this patient will not be able to return to this type of employment, please indicate below.

Patient's Name: Last ____ First ______________________________ MI ______

TYPE OR PRINT LEGIBLY
Diagnosis: The physician's diagnosis, **in layman terms**, must include and confirm the **catastrophic and incapacitating** nature of this patient's condition.

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____

Date physician diagnosed condition ___________________ Date treating physician last examined this patient ______________

Treatment Plan: Briefly explain the treatment plan, including any medication adjustments and frequency of appointments and/or therapy.

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Inability to Work: Please describe how this condition and its treatment inhibits the patient's ability to perform his/her professional duties. **Use the HCPSS job analysis provided by patient from HCEANEA.ORG to complete this section**.

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Date patient is anticipated to return to work.* ___________ **(Must be completed)** *The committee understands this may be adjusted.

____
Licensed Medical Doctor's Signature (Please include M.D., D.O., etc.)

____
Licensed Medical Doctor's Name (type or print – **MUST** be legible)

Both Physician Statement Forms must be completed and signed by the licensed treating physician.

Address of Physician (Street, City, State, Zip)

Physician's Telephone: