School District of Indian River County
Sick Leave Bank Program
Application for Withdrawal

All applications shall be processed through the Payroll Department. The Payroll Department will forward the application and required supporting documentation to the Sick Leave Bank Committee. The Committee will review the request and notify the Payroll Department of the decision within ten (10) working days.

**Please Print**

Employee Name: _____ Employee ID #: _____

Home Facility: _____ Job Title _____

Number of Days Requested: _____

Have you requested sick leave bank days for this illness since July 1st? Yes □ No □
(Three days unpaid may be waived for an instructional employee if illness/injury reoccurs during the same school year)

**In the event of catastrophic illness of a participating employee, causing him/her to be absent from work for an extended period of time, the employee may receive paid leave upon acceptance of the following criteria:**

***Please initial in the space provided as acceptance***

_____ I have expended all accumulated sick leave, followed by an unpaid leave of three (3) continuous workdays
_____ I am requesting sick leave days from the bank for a personal illness, accident or injury.
_____ I am not currently on leave for an injury or illness-in-the-line-of-duty, workman's compensation, or other approved leave (other approved leaves apply to teachers only)
_____ I am providing the Physician's Certification form (The form must be legible, personally signed by the physician, and completed in lay language. The committee will not honor any physician's statement unless it is on the official sick leave bank physician's certification form and is filled out in it's entirety.)

I certify that I have read and agree to abide by the rules governing the Sick Leave Bank. I hereby authorize any medical doctor, hospital, pharmacy, insurance company, employer or other organization to release any information regarding my medical history, treatment, disability or benefits payable for this claim to the Indian River County School District.

I further understand that a medical doctor's release statement will be necessary before I am allowed to return to work.

_____ ____/____/____
Signature Date

**For Payroll Use Only:**

Application received on: ____/____/____ Last day worked ____/____/____

Sick Leave expired on: ____/____/____

Number of days requested based on physician's certification and sick leave balance: _____

**Sick Leave Bank Committee:**

Approved for _____ days Waive 3 days unpaid □ Approved □ Denied □ N/A
Authorized Signatures (4 required): (waived for an instructional employee with reoccurring illness/injury)

_____ ____/____/____ □ Approved □ Denied
Signature Date

_____ ____/____/____ □ Approved □ Denied
Signature Date

_____ ____/____/____ □ Approved □ Denied
Signature Date

_____ ____/____/____ □ Approved □ Denied
Signature Date

_____ ____/____/____ □ Approved □ Denied
Signature Date

_____ ____/____/____ □ Approved □ Denied
Signature Date

_____ ____/____/____ □ Approved □ Denied
Signature Date

*School District of Indian River County*
*Sick Leave Bank Program*

# PHYSICIAN'S CERTIFICATION

*Employee Name*

| *(Print or type)* | *Last* | *First* | *Middle* |
|---|---|---|---|

*Address*

| | *Street* | *City/State* | *Zip code* |
|---|---|---|---|

**Authorization to release information:**
*I certify that I have read and agree to abide by the rules governing the sick leave bank. I hereby authorize any medical doctor, hospital, pharmacy, insurance company, employer or other organization to release any information regarding my medical history, treatment, disability or benefits payable for this claim to the Indian River County School District.*

*(Date)* _____ *Employee's Signature (or legal Representative)*

**The employee is responsible for the completion of this form at his or her own expense. The completed form must be returned to the Payroll Department. The form will be forwarded to the Committee who will review the request and all supporting documentation and notify the Payroll Department of the decision within ten (10) working days.**

***(To be completed by the Patient's Physician)***
***Please Print or Type***

**THE FOLLOWING QUESTIONS APPLY ONLY TO THE CONDITIONS RELATED TO THE PATIENT'S APPLICATION FOR WITHDRAWAL FROM THE INDIAN RIVER COUNTY SCHOOL BOARD'S CATASTROPHIC SICK LEAVE BANK PROGRAM**

**1. HISTORY**

*a) When did patient first seek treatment for this illness/injury?* _____ *Month* _____ *Day* _____ *Year*

*b) Could this illness/injury be work related?* *Yes* ☐ *No* ☐

*c) To your knowledge has patient ever had the same or similar condition ?* *Yes* ☐ *No* ☐
*If "Yes", state when and describe:*

**2. PRESENT CONDITION**

*a) Is Surgery:* *Required?* ☐ *Elective?* ☐ *Date of Surgery:* _____

*When was the patient informed by the attending physician?* _____ *Month* _____ *Day* _____ *Year*

*b) Is patient? (Check one)* ☐ *Ambulatory* ☐ *House Confined* ☐ *Bed Confined* ☐ *Hospitalized*

**3. DIAGNOSIS:**

*Give a brief narrative of the nature and extent of the present illness/injury which is creating the need for compensation from the Indian River County School Board Sick Leave Bank:*



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*REV: 2014*
*GS1-SL-Item #116*

**4. CONTINUING REQUIRED TREATMENT FOR THIS ILLNESS/INJURY**

*a) Projected Date of first office visit/treatment* _____ Month _____ Day _____ Year

*b) Frequency of visits/treatments* *Weekly* ☐ *Monthly* ☐ *Other* _____

*c) When did you last examine the patient?* _____ Month _____ Day _____ Year

*d) Give a brief description of the continuing treatments required by this illness/injury:*

**5. PROGNOSIS AND ANTICIPATED TIME DURATION THAT EMPLOYEE WILL BE UNABLE TO WORK DUE TO THE HEALTH CONDITION OF THE EMPLOYEE**

*a) If there are no further complications, what is the minimum recovery time of the patient before the employee may return to work?*
*Approximate return date:* _____

*b) What is the maximum recovery time of the patient before the employee may return to work?*
*Approximate return date:* _____

***A "catastrophic health condition" is defined as an illness, injury, or impairment that will result in an employee's temporary or permanent incapacity to perform his or her job function for an extended period of time.***

**I certify that the information above concerning the named employee of the School District of Indian River Count is correct and that the related injury/illness meets the criteria of catastrophic sick leave as defined above and interpreted by me.**

_____
*Signature of Attending Physician*

*Please type or print physician's name and address and phone number:*

_____

_____

_____

_____