Sick Leave Bank – Application to Receive Days

Human Resources

General requirements for receiving days from the Sick Leave Bank

Please be sure to read and follow all instructions carefully.

1. The staff member has incurred a Medical Emergency (as defined by the Sick Leave Bank), where the staff member or the spouse or child of the staff member suffers from an extraordinary or severe illness, injury, impairment or physical or mental condition which has caused, or is likely to cause the staff member to go on a prolonged leave of absence or terminate their employment.
2. The staff member's need for prolonged absence is substantiated by a physician.
3. The staff member has depleted all forms of paid leave and has been absent from work for at least thirty (30) consecutive work days for the same illness/disability, whichever shall occur last.
4. The staff member has abided by District rules regarding sick leave use. The staff member is required to sign an authorization form to use or disclose protected health information (PHI) so the Sick Leave Bank Committee can access their absence and health records.
5. The staff member is currently employed as a licensed staff member in Community High School District 155 and is a member of the Teacher Association and is a current participant in the Sick Leave Bank.
6. The staff member will be able to submit, prior to approval or disapproval, the "Certification of Health Care Provider – Sick Leave Bank" form. Contact Valerie Ksiazek, Benefits Coordinator, in HR at (815) 455-8500, ext. 1021 for paperwork.
7. The staff member has complied with all application and documentation procedures and is otherwise eligible to access days from the Sick Leave Bank as determined by the conditions and guidelines of the Sick Leave Bank.

Employee Information

_____ _____ _____
Employee's Name (please print) Building Location School Year

☐ I wish to apply for use of the Sick Leave Bank and I am requesting _____ days from the Sick Leave Bank.

☐ I have previously donated the required one (1) day to the Sick Leave Bank.

☐ I have attached the situation/reason for request on a separate sheet of paper.

☐ I have attached the "HIPAA release" form *and* the "Certification of Health Care Provider-Sick Leave Bank" form (Contact Valerie Ksiazek, Benefits Coordinator, in HR at (815) 455-8500, ext. 1021 for paperwork).

I have previously used a total of _____ days from the Sick Leave Bank during my employment with District 155.

_____ _____ *If submitting form electronically, initial here:*_____
Employee's Signature Date

Human Resources Office Use Only

Contractual Days Remaining in the School Year: _____ as of _____ Sick Balance: _____ as of : _____

Used all Available Leave (Sick/Personal) on: _____ *Or* Projected to Use All By: _____

Number of Days Without Pay: _____ If "0", Projected date to exhaust 30 required days: _____

Is employee on Worker's Compensation? ☐ Yes ☐ No Date Eligible for TRS Disability: _____

_____ _____
Signature of H.R. Staff Member Date

District Sick Leave Bank Committee Use Only

☐ Application Approved for _____ days ☐ Application Denied – Reason stated on attached sheet

_____ _____ _____
Signature of Committee Member Date Comments

Distribution: ☐ Sick Bank Master File ☐ Employee Medical file

Community High School District 155
Authorization to Use and Disclose
Specific Protected Health Information

By signing this Authorization, I, the undersigned, hereby direct the use or disclosure by Community High School District 155 ("School District") of medical information pertaining to my health, my health care, or me for the purpose of requesting use of banked sick leave, including information regarding absence, attendance and health records.

This information may be used or disclosed by the School District and may be disclosed to and used by the Sick Leave Bank Committee and its members for the purpose of administering the Sick Leave Bank and reviewing, approving or disapproving my request for use of Sick Leave Bank days.

I understand that I have the right to revoke this Authorization at any time except to the extent that the School District has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the School District as follows:

Community High School District 155
ATTN: Valerie Ksiazek, Benefits Coordinator
One South Virginia Road
Crystal Lake, IL 60014
Telephone: (815) 455-8500, extension 1021

I understand that the School District may not condition treatment or payment on whether I sign this Authorization. The School District may condition enrollment in the health plan or eligibility for benefits on provision of an authorization prior to enrollment if: 1) the authorization is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations; and 2) the authorization is not for a use or disclosure of psychotherapy notes.

In addition, the School District may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party. I further understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that except for the use or disclosure of psychotherapy notes, my written Authorization is not required for the School District to use my protected health information for treatment, payment or health care operations, to defend itself in a legal action or other proceeding brought by me, or as otherwise permitted or required by the HIPAA Privacy Standards.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by the School District and the Sick Leave Bank Committee for determination of approving or disapproving my request for use of banked sick leave.

The use or disclosure of the requested information will not result in direct or indirect remuneration to the School District from a third party.

The Authorization expires on (check one):

___ a final determination of approval or disapproval of my request for use of banked sick leave.

___ (specific date) _____.

___ (other) _____.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

Name of Employee: _____

By (if applicable): _____

Authority to Act on Behalf of Employee (if applicable): _____

Signed: _____

Date: _____

NOTE: A signed copy of the Authorization must be provided to the individual. This Authorization must be completely filled out for it to be valid.

Note: The *Genetic Information Nondiscrimination Act of 2008* prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.