SAN ANGELO INDEPENDENT SCHOOL DISTRICT

Catastrophic Sick Leave Bank

Request

Print

Name	Employee ID #
Position	Campus / Department

Reason for requesting days and nature of illness or injury:______________________________________

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First day of treatment for this absence:___________________

Do you expect additional days for follow examination for treatment? _____Yes _____No

Requesting days for: ____ Self ____ Spouse ____ Child ____ Other___________________________

Days requested from Bank ______/_____/____ through _____/_____/_____

Total number of days requested:_______________________________________

Information to be included in the certification of health care provider:

Identification and nature of this illness and/or extent of this illness or injury (explanation in layman's terms is preferred).

Anticipated date eligible to return to work, either full time or part time.

Anticipated days, if any, for follow-up examination or treatment.

I have exhausted all my accumulated paid leave, including vacation and compensatory time.
I hereby authorize the Catastrophic Sick Leave Board to obtain further information pertaining to this request from my attending physician: ______Yes ______No
The certification of health care provider is attached.

Signature____Date________________

Human Resources Department Use Only

Membership effective date__________________________________

Prior days approved____

Notes____

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