Regional School District No. 17
Office of the Superintendent

SUPPORT SERVICES ASSOCIATION
REQUEST - SICK BANK FORM
INSTRUCTIONS

1. Employee completes Sick Bank Request Form.
2. Doctor completes Sick Bank Physician's Statement.
3. Send forms to: Pamela Hensel, Administrative Assistant to the Superintendent

Regional School District No. 17
57 Little City Road
Higganum, CT 06441

Please Note:

The following criteria will be used to determine the eligibility of a member to receive donations and to determine the number of days to be donated:

1. A member must have a catastrophic illness or injury or combination thereof and must provide timely and competent medical certification of the catastrophic illness or injury or combination thereof.

2. A member must have exhausted all accumulated sick leave.

3. A member shall not be entitled to any other paid leave, remuneration from disability payments, workers' compensation, and/or other such benefits.

If the Superintendent and the Association representative have agreed to activate the sick leave bank, donations will be accepted by the Board on a first come, first serve basis until the number of days donated to the eligible member totals sixty (60) days.

Members who donate paid days to the eligible member shall have the days deducted from their total accumulated sick leave.

Once donations have been accepted, the Superintendent and the Association representative may issue a grant of days from the Sick Leave Bank of no more than sixty (60) days to any individual member.

The aggregate number of days donated in any school year shall be a maximum of one hundred eighty (180) days.

Regional School District No. 17
Office of the Superintendent
SUPPORT SERVICES ASSOCIATION SICK BANK REQUEST FORM

Name: _____

Address:
_____
_____
_____

School and Department:
_____

Home Phone: _____

REQUEST
Number of Days _____ (Maximum of 60)
Start Date*: _____
End Date: _____
Estimated Return to Work Date: _____

Attending Physician:
_____

I have attached my Physician's statement
Comments:
_____
_____
_____

I have a catastrophic illness or injury or combination therefore and have provided timely and competent medical certification of this condition.

Member Signature _____

Date: _____

********** ***(office use only)***

Accumulated Sick Days _____as of _____

Approve / Deny

The above member does / does not meet the criteria for sick bank usage as stated in the Support Services Association contract under Section XXIV, Sick Leave Bank

_____ _____

Union Representative, Date

Approve / Deny

The above member does / does not meet the criteria for sick bank usage as stated in the Support Services Association contract under Section XXIV, Sick Leave Bank

_____ _____

Superintendent of Schools, Date

Number of Days Approved: _____

Competent medical certification confirming the catastrophic illness, injury or combination thereof has been received: YES / NO

_____

___ ***Copy to Payroll***

___ ***Copy to Benefits***

___ ***Copy to Attendance***

___ ***Approval sent to member's home***

___ ***Board of Education notified of sick bank use***