

Hardin County Schools
Sick Leave Bank Usage Application

(page 1 of 3)

NOTE: Before completing this application, all paid leave time must be exhausted.

Name: _____

Address: _____

Social Security Number: ____ - ____ - ____

EIN: _____

Job Title: _____

Job Location: _____

In completing a Sick Leave Usage Application, I agree to the following:

1. To provide a detailed statement from the attending physician of the applicant or applicant's family member (page 2 of this application);
2. For my complete leave record to be made available to the Sick Leave Bank Usage Approval Committee;
3. If approved, to provide sick leave cards for days granted; and
4. Affirm that all of my paid-leave time has been exhausted.

Employee Signature _____ Date _____

Submit Complete Application to: Human Resources
Hardin County Board of Education
65 W.A. Jenkins Road
Elizabethtown, KY 42701-8452

Note: Must submit a new form every month days are needed for consideration.

Date received in Central Office _____

Sick Leave Bank Usage Application Physician Statement

Sick Bank Applicant Social Security Number: _____ - _____ - _____

Please check one:

_____ This physician statement is for me.

_____ This physician statement is for my immediate family member
(as defined by district policy for sick leave). Sick bank applicant is responsible for obtaining all
required releases from patient for physician.

THIS PORTION MUST BE COMPLETED BY A PHYSICIAN:

*NOTE TO PHYSICIAN: Please do not use names on this page when completing the information requested.
Please refer to as "patient" only.*

1. a. Was surgery involved? _____ yes _____ no

b. If yes, was it: _____ elective _____ non-elective

2. Dates patient was restricted from working OR dates that required care from a family member:

3. Date patient released to return to work OR date that care from family member no longer required:

4. Date and nature of illness/medical condition that prevented patient from working
OR Dates and nature of illness/medical condition that required care from a family member:

Physician's Signature _____ **Date Signed** _____

Sick Leave Bank Usage Application

PLEASE BE SPECIFIC AND FILL OUT COMPLETELY

EIN _____

Number of Days Requested: _____ Hire Date: _____ Date of this form: _____

Specific dates that you had leave without pay (*you may only apply for dates in the past, not in the future*):

Reason for Sick Bank Leave request - please check those that apply:

- _____ 1. Serious accident by the employee requiring extended work absences
- _____ 2. Serious illness of the employee
- _____ 3. Extended hospitalization of the employee
- _____ 4. Other serious extenuating circumstances normally allowed for sick leave
(extenuating circumstance as approved by the Usage Approval Committee)

Provide very specific information (including specific dates) for this sick leave request. Add pages if needed.

You may provide any helpful information about how you have used your days in the past if you believe it will help the committee better understand your need. Add pages if needed.

FOR COMMITTEE USE ONLY:	NUMBER OF DAYS APPROVED _____
Committee Administrator _____	Date: _____
Committee Member _____	Date: _____
Committee Member _____	Date: _____
Committee Member _____	Date: _____
Committee Member _____	Date: _____