PROCEDURES FOR REQUESTING EXTENDED SICK LEAVE

Employees that have a catastrophic injury or illness for themselves or an immediate family member or an employee that will be having a baby are eligible to request 25 days of extended sick leave to be used consecutively after all local and state leave have been exhausted.

This leave is at a prorated rate of $70.00 per day.

Once extended sick leave has been exhausted the rate will increase to the employees' current daily rate of pay.

Extended Sick Leave can only be requested once per school year per employee

1. Campus Principal or Department Head will need to send an email to kim.martin@whitneyisd.org requesting Extended Sick Leave for the employee.
2. Employee will submit the form along with a doctor's note to the HR / Business Office.
3. Once approved the 25 days of extended leave will be placed in your leave account and can be seen in Frontline as well as your Employee Payroll Portal.

Updated 08-26-2022

REQUEST FOR EXTENDED SICK LEAVE DAYS

Please complete this form and return to the Business Office. An official **Extended Sick Leave Request and also an Attending Physician's Statement** must also be submitted before this request can be considered. Extended Sick leave days shall be used for a catastrophic illness or injury of the employee or immediate family member or maternity leave for new mothers. Leave must be used consecutively.

Date: _____/_____/_____

Employee Name: ____

Address: ____

Telephone: ______________________________ Campus/Dept. ______________________________

Patient's name if different than above: ______________________ Relationship to employee: ______________________

I have or will have used all my available state and local leave, as well as any compensatory time and vacation days, as applicable.

I am requesting leave: Begin: _____/_____/_____ End: _____/_____/_____

Nature of illness or injury*:

____

____

____

Date illness began or accident occurred: _____/_____/_____ Date physician consulted: _____/_____/_____

Name, address, and phone number of attending physician:

____

____

____

Did the condition require hospitalization? Yes _____ No _____

If yes, please complete the following information:

Name of hospital: ____

Dates of confinement: Begin: _____/_____/_____ End: _____/_____/_____

I certify that the information given on this request for extended sick leave days is accurate and true.

Signature of Employee: ______________________________ Date: ______________________

*** GINA NONDISCLOSURE NOTICE:** The Genetic Information Nondiscrimination Act of 2008 (GINA) 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.

For Business Office Use Only

Date Received: ______________

Date Employee Enrolled in Catastrophic Extended Leave: ______________

Date Decision Communicated to Employee: __________ Granted _____ Denied _____