KILGORE Independent School District

MEMBER REQUEST TO USE SICK LEAVE BANK DAYS

This form should be completed by the employee or person acting on the employee's behalf: Eligible conditions must meet the definition of catastrophic illness or injury as presented in the KISD Sick Leave Bank Guidelines. Please print clearly.

Member Name: _____ Employee ID#:_____

Home Address: _____

Telephone # :_____ Current Member of Sick Leave Bank? ☐ Yes ☐ No

Last Day of Work: _____ Expected Date of Return to Work: _____

Last Day of All Accumulated Leave (Local, State, Comp Leave):_____

Number of Sick Leave Bank Days Requested (*max 30 days annually*): _____

Will this leave be: ☐ Consecutive Days ☐ Intermittent (see SLB Guidelines on use of intermittent time)

Nature of Catastrophic Illness or Injury: _____

_____

Catastrophic Illness/Injury of: ☐ Member ☐ Member's Immediate Family Member

If immediate family member, relationship to Member and name: _____

I hereby certify that the information given to the KISD Sick Leave Bank Employee Committee is valid to the best of my knowledge.

Member Signature _____ Date _____

The Sick Leave Employee Committee meets monthly to review requests. Please return the *Member Request to Use Sick Leave Bank Days* accompanied with the *Physician's Statement* to Mrs. April Cox, Executive Director of Administrative Services in-person, via email at acox@kisd.org, or by mail to:

Kilgore Independent School District
c/o Mrs. April Cox, Executive Director of Administrative Services
301 N. Kilgore Street
Kilgore, Texas 75662

KILGORE Independent School District

301 N. Kilgore Street
Kilgore, TX 75662
Phone: 903.988.3900
Fax: 903.983.3212
www.kisd.org

EMPLOYEE SICK LEAVE BANK PHYSICIAN'S STATEMENT

The information below should be filled out by the patient's physician and will remain confidential.

Patient's Name: _____

"A catastrophic illness or injury is a critical, severe, debilitating, and life-threatening condition or combination of conditions affecting the health of patient and requires treatment by a licensed practitioner for a prolonged period of time. Such conditions typically require prolonged hospitalizations or recovery."

If it is in your professional opinion that the patient's illness or injury is catastrophic as defined by the definition above, please complete the form below.

Date of diagnosis: _____/_____/_____

Diagnosis and Nature of the Illness/Injury:_____

_____

Have you treated the patient previously for this condition? _____ Yes _____ No

Treatment Plan: _____

_____

Prognosis: _____

Is the patient still under your care? _____ Yes _____No

Approximate end date of treatment: _____/_____/_____ Comment: _____

I hereby certify that the information given on this Physician's Statement is accurate and true.

Signature of Physician: _____ Date: _____

Name of Physician: _____

Address: _____

Telephone number: _____