IN ORDER TO BE CONSIDERED, ALL APPLICATIONS MUST BE SUBMITTED NO LATER THAN FOUR WEEKS AFTER THE OCCURRENCE.
According to article 4.2.4.4 in the negotiated agreement, if the application is submitted AFTER the member returns to work, the application WILL BE DENIED.

APPLICATION FOR SICK LEAVE BANK BENEFITS

Applicant's Statement of Illness (Please print or type)

NAME_____

ANY FORMER NAMES (Maiden etc.) _____

ADDRESS_____

HOME PHONE_____CELL PHONE_____E-MAIL_____

POSITION_____BUILDING_____

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE NUMBER: _____

****

REASON FOR APPLYING: _____

DATE ABSENCE BEGINS:_____ APPROXIMATE RETURN DATE:_____
(***If you are pregnant, please list your due date. You will need to notify a committee member with the exact date the baby is born before coverage will begin.***)

APPROXIMATE TOTAL NUMBER OF DAYS REQUESTED AFTER
YOU USE 10 CONSECUTIVE DAYS OF SICK LEAVE _____
*****If requesting more than 6 weeks, an updated medical statement will be required.*****

****

I authorize the Sick Leave Bank Committee to confer with my physician in regards to the number of days required for my recuperation. I also understand that I could be required to obtain a second opinion before the bank will grant days. This cost will be paid by me. I can amend this application but a new doctor's statement will be required and a second opinion may be required at that time.

I understand that I have to be absent from work due to sick leave for ten (10) consecutive work days before the bank will contribute. After I have met the ten consecutive days of sick leave, I understand that IF the bank accepts my application, it will grant four days and I will contribute one day for the duration of the grant. If I do not have sick days or personal days to cover, I will lose pay for that day. I also understand that I can find more information about the sick bank and its policies in the negotiated contract, Article 4 and Appendix A.

DATE_____

APPLICANT'S SIGNATURE_____
*****Digital signature WILL NOT be accepted*****

RETURN THIS APPLICATION AND THE MEDICAL STATEMENT FORM TO A SICK LEAVE BANK COMMITTEE MEMBER:

Connie Irick - Washington Elementary
Macy Jeffery - Wilcox Elementary
Franciena Steinmetz- Alameda Middle School
Cheryl Howell - District Office Payroll
Diane Hansen - District Office Human Resources

You can fax your application to
Attn: Diane Hansen
208-235-3280
*****Please call to confirm that we received your application*****

IN ORDER TO BE CONSIDERED, ALL APPLICATIONS MUST BE SUBMITTED NO LATER THAN FOUR WEEKS AFTER THE OCCURRENCE.

According to article 4.2.4.4 in the negotiated agreement, if the application is submitted AFTER the member returns to work, the application WILL BE DENIED.

MEDICAL STATEMENT

*****Employee fills out this section*****

DATE_____

EMPLOYEE'S NAME_____

I hereby authorize the release of any/all medical information related to the treatment I, or my dependent, have received or are now receiving.

EMPLOYEE'S SIGNATURE_____

*****Digital signature WILL NOT be accepted*****

*****The section below must be filled out by medical professionals*****

School District No. 25 requests the following information regarding the illness, injury, and/or disability incurred by our employees that required the care of a medical practitioner. This information is needed to determine the number of Sick Leave days needed for the patient to physically recuperate from the illness or injury. If you require more space, please attach additional information or documents. **Any statement that is vague or unclear can result in a denial of the grant.** Please be complete and realistic in regards to the amount of time the applicant needs to refrain from working.

PATIENT'S NAME_____

DATE FIRST SEEN_____

DATE THE INJURY OR ILLNESS OCCURRED_____

EXPECTED DATE FOR PATIENT TO BEGIN MEDICAL LEAVE_____

Please explain why the patient is unable to work at this time.

_____

_____

Please explain (layman's terms) the nature of the condition or diagnosis.

_____

_____

Please explain the short or long term effects due to treatment, surgery or medication(s) that we need to know to understand the illness or injury. (Prognosis)

_____

_____

Please explain what continued treatment, therapy or medication(s) have been prescribed or ordered if any.

_____

_____

What is the estimated date you anticipate the patient will be recovered and **able** to return to work?

_____

Physician's Signature (required)_____

*****Digital signature WILL NOT be accepted*****

Date_____