



HUMAN RESOURCES DEPARTMENT

651-351-8340

www.stillwaterschools.org

1875 South Greeley Street
Stillwater, MN 55082



SHORT TERM DISABILITY OR SICK BANK LEAVE APPLICATION

Employee's Name _____ Date _____

Job Title _____

Supervisor Signature _____ Location _____

Leave start date or estimated due date _____ End Date _____

This Disability Leave is for:

- Birth/Adoption/Foster care of a child
- Serious health condition of employee
- Serious health condition of family member:
 - Child
 - Spouse
 - Parent

Will you be using any accrued sick leave during this leave? No Yes How many days? _____

If enrolled in the Sick Bank, would you like to request sick bank days? No Yes How many days? _____

Will you be using any accrued vacation time during this leave? No Yes How many days? _____

Will this leave be taken in an intermittent/reduced schedule? No Yes How many days? _____

I understand that I must work at least four hours per day to qualify for short term disability. I understand that I must have enrolled in the sick leave bank during the enrollment period to be able to request sick bank leave days.

I understand that my insurance benefits will be continued during my leave provided I continue paying the full premium unless a portion is district paid under the current Master Contract/Salary Program language. If insurance premium is not deducted from my paycheck, it is due by the twenty fifth (25th) of each month. If payment is not made within 30 days, I understand that my benefits may be discontinued.

I understand that the school district will return me to the same or an equivalent position on return from leave. However, I will not be eligible for reinstatement if a workforce reduction or layoff occurs while I am on leave and I would have been affected had I been working full time or part-time.

Leave for the serious health condition of the employee requires medical certification, completed by medically disabled individual's physician: 1) before the leave begins or as soon as practical; 2) while on leave to re-certify medical need as necessary; and 3) authorizing return to work for employee's own illness to determine fitness for duty.

Employee's signature _____ Date _____

Human Resources Department Approval _____ Date _____

Afton-Lakeland Elementary, Andersen Elementary, Brookview Elementary, Early Childhood Family Center, Lake Elmo Elementary, Lily Lake Elementary, Oak-Land Middle School, Rutherford Elementary, St. Croix Valley Area Learning Center, Stillwater Area High School, Stillwater Middle School, Stonebridge Elementary