Non Certified Employee Sick Leave Bank Withdrawal Request Instructions

The Non-Certified Employee Sick Leave Bank (SLB) was established to be used in the event of a catastrophic (life-threatening) illness, surgery, a temporary disability requiring extended hospitalization or home confinement, or for the same reasons involving immediate relatives of the employee when the employee is the sole caregiver for the relative. Normal pregnancy, child care, and elective surgery are not considered to be valid reasons for use of the sick leave bank.

Use of Non-Certified Employee Sick Leave Bank is only available for SLB members.

Instructions:

1. Complete top portion of Request Form, making sure to sign and date, as requested.
2. Have treating medical professional complete bottom portion. Provider must sign and provide contact information; otherwise form will not be accepted.
3. Submit a letter explaining the circumstances surrounding the request.
4. Completed paperwork should be submitted to the designated Nurse, or to the Sick Leave Bank Committee Chair

- Sick Leave Bank Committee Chair

  Jennifer Slack
  Carriel Junior High School
  451 N. Seven Hills Rd.
  O'Fallon, IL 62269
  Fax: 618-622-2940

- School Nurse

  Cynthia Tole
  Estelle Kampmeyer School
  707 N. Smiley St.
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O'Fallon Community Consolidated School District 90

NON-CERTIFIED PERSONNEL SICK LEAVE BANK WITHDRAWL REQUEST FORM

To be completed by employee:

Employee Name: _____ School: _____

Is this for [ ] employee [ ] family member (Check one)

Number of regular sick leave days available _____ personal days _____vacation days_____

Date anticipated having exhausted sick / personal / vacation leave days: _____

Number of days being requested: _____

Previous withdrawal from bank: Date: _____ Days _____

Is this due to a Workman's Compensation injury? Yes No (circle one)

I hereby authorize my health care provider (print name: _____) to release the information requested to complete this form.

Signature: _____ Date: _____

To be completed by licensed health care provider:

Medical Condition: _____

Date of Injury: _____ Date of Hospitalization: _____

Date of Surgery: _____ Type: _____

Dates off work: FROM (date):_____TO: (date)_____

For_____school days. This request must be renewed after the time requested has expired

in accordance with the rules and restrictions of the OSPF Sick Leave Bank language

Next visit with Health Care Provider: _____

Provider's Signature: _____Date: _____

Phone: _____ Fax: _____