Duncanville ISD Sick Leave Bank Benefits Application

You must be a current member of the Sick Leave Bank in order to request benefits

EMPLOYEE INFORMATION

Name: _____ Employee ID# _____

Campus/Location: _____ Position: _____

Phone #: _____ Alternate #: _____

Date of Request: _____ Number of total days requested: _____ (Maximum 30 days per year)

Date of First Absence: _____ Expected Return to Work Date: _____

Employee's Signature: _____

Representative's Signature (If employee is unable to sign): _____

Representative's relationship to employee: _____

REASON FOR REQUESTING BENEFITS

Employee illness/injury (specify medical condition): _____

_____

_____

☐ Critical Care (name and relationship of family member): _____

☐ Bereavement (Name and Relationship of Family Member): _____

☐ Describe the care you will provide to your family member: _____

_____

_____

FOR DISTRICT USE ONLY

Eligible member? _____ Eligible absence? _____ 10 consecutive days of absence? _____

Number of SLB days used this school year: _____ (max 30)

☐ Approved by SLB Board – Number of days approved: _____

☐ Not approved – Reason: _____

☐ Deferred – Reason: _____

Signature of SLB Chairperson: _____ Date: _____

DUNCANVILLE ISD

Writing success stories, one student at a time.

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Attending Physician's Statement

Please email the completed form to leave@duncanvilleisd.org or fax it to 972-767-0971.

MEDICAL INFORMATION RELEASE

Employee's Name: _____ Employee ID# _____

Patient's Name: _____ Relation to Employee: _____

"I authorize the release of my medical information to the Duncanville ISD Sick Leave Bank Committee."

Employee/Patient Signature: _____ Date: _____

PHYSICIAN'S STATEMENT

For all injuries/illness – DIAGNOSIS: _____

_____

_____

Date of earliest diagnosis/treatment: _____ Estimated duration of condition: _____

FOR ALL SURGERIES – Surgery recommendation: _____

Yes ☐ No ☐ Could the recommended surgery be scheduled during the summer months without being detrimental to the patient's health?

Yes ☐ No ☐ Was the employee/family member hospitalized? If yes, how long? _____

Yes ☐ No ☐ Will the employee/family member be incapacitated for a single continuous period of time?

If yes, estimate the beginning and ending dates for the period of incapacity: _____ to _____.

Anticipated treatments or therapies after initial release to return to work: _____

_____

_____

_____ _____

PHYSICIAN'S NAME (Please print) PHYSICIAN'S SIGNATURE

_____ _____ _____

Address Office phone number DATE

_____

City, State, Zip code