PITTSBURG COMMUNITY SCHOOLS USD 250

510 Dell, PO Drawer 75, Pittsburg, KS 66762 Phone: (662) 235-3100 Fax: (662) 235-3106

Application for USO 250 Sick Leave Pool

Employee Name: _____

School Building: _____

Date of application being submitted: _____

To be completed by Employee:

1. Have you used all of your accumulated sick leave and personal leave?
   ☐ Yes, I have used or will use all my sick and personal leave by the first day of my sick leave pool leave request.

2. The reason I am requesting these days meets the requirements for sick leave pool eligibility. PNA: Section IX: "The sick leave pool shall be used in the event of prolonged medical condition."
   ☐ Yes, I am under a doctor's care for a prolonged medical condition.

OR

   ☐ Yes, an eligible family member is under a doctor's care for a prolonged medical condition. Eligible family members: spouse, domestic partner, parents of the employee or spouse, or domestic partner, and children or stepchildren of the employee.

	Number of Days	Dates:
Consecutive Leave		First Day: Final Day:
*Intermittent Leave (to be used intermittently after returning to work for continuing care of the prolonged medical condition)		From: To:
TOTAL Number of Days		

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To be completed by Employee and Building Administrator or Human Resources:

My Building Administrator or Human Resources:

- ☐ Reviewed with me how to access the negotiated agreement online.
- ☐ Reviewed with me the rules, procedures, and options for applying for sick leave pool, extended leave, and catastrophic leave.
- ☐ Reviewed with me Family Medical Leave Act (FMLA) including rules specific to school employees.
- ☐ Answered all of my questions.

Employee Signature: _____Date:_____

Building Administrator or Human Resources: _____Date _____

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Employee Name: _____

Patient's Name if not employee: _____

Relationship to Employee: _____

☐ The Sick Leave Pool form will be accompanied by a signed written statement on letterhead from the employee's physician or physician of the eligible family member certifying that the employee is incapable of performing their duties as a result of the prolonged medical condition. The physician will certify in writing the number of days of absence the prolonged medical condition requires.

By my signature below, I agree to the release of information to facilitate this request from my physician to Pittsburg Community School District USO 250 and Sick Leave Pool Screening Board.

Employee Signature: _____ Date _____

To Be Completed by Physician:

Name of Patient:_____

Prolonged Medical Condition: _____

Anticipated dates to be off work: _____

Anticipated estimated number of days for additional follow up appointments: _____

My signature below affirms that

_____

is a patient under my care during the time periods noted above. The above-named patient is incapable of performing essential functions of their job during the time stated, or if the patient is not the employee, the patient has a serious, prolonged medical condition. The patient may also have follow-up appointments.

Physician Signature: _____ Date _____

*Copy for your records and send the original to the Human Resources at USD 250.