

**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 \_\_\_\_\_

CELL/HOME 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 is 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.

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\*\*\*Digital signature is not accepted\*\*\*

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

Sherri Christensen – Pocatello High School  
Sarah May Clarkson – Highland High School  
Janella Jones – Syringa Elementary  
Cheryl Howell – District Office Payroll  
Shawna Miller – District Office Human Resources

**You may fax your application:**  
  
**Attention: Shauna Miller**  
**(208)235-3280**  
  
**Please call to confirm the fax was received.**

sickleavebank@sd25.us

**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 is not accepted\*\*\*

\*\*\*\*\*

**\*\*\*The section below completed by medical professional.\*\*\***

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) \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Digital signature is not accepted\*\*\*