

Request for Catastrophic Sick Leave Days

Employee Number: _____	Date of Hire: _____
Employee First Name: _____	Employee Last Name: _____
Campus/Department: _____	Position: _____
Email: _____	Phone: _____
Duty Calendar: _____	

I am requesting Catastrophic Leave Days for:

- ☐ My own injury/illness
- ☐ An immediate family member's injury/illness

Immediate family member's name: _____

Immediate family member's relationship: _____

Number of days requested from the Catastrophic Sick Leave Bank: _____

First day of absence for injury/illness: _____

Last day of absence for injury/illness: _____

Do you anticipate any additional days to be needed for follow-up exams? ☐ Yes ☐ No

Do you have an open Worker's Compensation Claim for the above request? ☐ Yes ☐ No

The above requested days are needed for the reason of a catastrophic illness as described in the attached physician's statement, for myself or that of my spouse or child.

I hereby authorize the Catastrophic Sick Leave Bank Committee to obtain further information pertaining to this request from an attending physician. ☐ Yes ☐ No

Do you authorize the release of your FMLA paperwork in lieu of the Catastrophic Sick Bank Physician's Statement? ☐ Yes ☐ No

Signature:

Date:

**Catastrophic Sick Leave Bank
Attending Physician's Statement**

TO THE ATTENDING PHYSICIAN: Your patient or the patient's family is requesting extended sick leave benefits from the Northwest Independent School District that will afford our employee full payment of up to 30 days of sick leave in the event they are able to work due to a catastrophic illness or injury or need to care for a covered family member with a catastrophic illness or injury. Prior to approving any payment for days lost, a doctor's statement is required concerning the patient's illness.

Please email the completed information below to shannon.barton@nisdtx.org.

Employee's Name: _____

Patient's Name: _____ Relationship to Employee
☐ Spouse ☐ Child ☐ Parent

Relevant medical facts pertaining to this condition: (Layman's language please)

Dates and Treatment for this condition:

If patient was hospitalized: _____ Date Admitted: _____ Date Discharged: _____

If there were complication arising from this illness/injury/surgery, please explain:

Is this an elective procedure or any procedure that could be scheduled without detriment to the member's health, at a time more compatible with the member's work responsibilities? ☐ Yes ☐ No

Identify the job functions the employee is not able to perform, or the functions the employee will be providing to the family member:

Expected date employee can return to work: _____ Date Admitted: _____

If additional follow-up appointments/treatments will be needed, please describe:

Date

Physician's Signature

Physician's phone number

Physician's Printed Name