O'Fallon District 90
Learning today, leading tomorrow

Dr. Carrie Hruby
Superintendent
Dr. Joi Wills
Assistant Superintendent

118 E. Washington St. O'Fallon, IL 62269
Phone: 618. 632.3666 | Fax: 618. 632.7864
www.of90.net

CERTIFIED STAFF SICK LEAVE BANK WITHDRAWAL 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: _____

Date anticipated to have exhausted sick and personal leave days: _____

Number of days being requested: _____

Previous withdrawal from bank: Date: _____Days: _____

Per the CBA, there are specific criteria for which requests may be granted. Please check from the following list:

___catastrophic illness (defined as a life-threatening illness)

___surgery,

___a temporary disability requiring extended hospitalization or home confinement*,

___or for the above reasons involving immediate relatives of the employee when the employee is the sole caregiver for the relative.

*Home confinement is specifically limited to contagious or autoimmune conditions and is required by doctor's order.

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

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

Employee Signature: _____Date: _____

SCHOOL BOARD MEMBERS

Eric Andrew Member | **Quennetta Chambers** Vice President | **Becky Drury** Secretary | **Mary Lynam-Miller** Member | **Ankur Patel** Member | **Emily Sackett** Member | **Laura Van Hook** President

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To be completed by physician: (This request must be renewed every 30 school days.)

Medical Condition: _____

Date of Injury: _____ Date of Hospitalization:_____

Date of Surgery: _____ Type: _____

Date to return to work: _____

Next visit with Doctor: _____

Dr. Signature: _____Date:_____

Phone: _____Fax: _____

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