

**IN ORDER TO BE CONSIDERED, ALL APPLICATIONS MUST BE SUBMITTED IN COMPLETION
NO LATER THAN FOUR WEEKS AFTER THE OCCURRENCE.**

Keep in mind, the sick leave bank committee meets bimonthly during the summer months.
According to article 4.2.d in the negotiated agreement, if the application is submitted AFTER the
member returns to work, the application WILL BE DENIED.

**ALL INFORMATION MUST BE COMPLETED BY EMPLOYEE AND ATTENDING MEDICAL
PROFESSIONAL OR IT WILL BE DENIED. Leave nothing blank.**

APPLICATION FOR SICK LEAVE BANK BENEFITS

Applicant's Statement of Illness (Please print or type):

NAME _____
ANY FORMER NAMES (Maiden etc.) _____
DATE OF BIRTH _____
ADDRESS _____
HOME PHONE/ CELL PHONE _____
PERSONAL E-MAIL _____
POSITION _____ BUILDING _____
PHYSICIAN'S NAME: _____
PHYSICIAN'S ADDRESS: _____
PHYSICIAN'S PHONE NUMBER: _____

REASON FOR APPLYING (Diagnosis): _____
DATE ABSENCE BEGINS: _____
APPROXIMATE RETURN DATE (must be completed): _____

APPROXIMATE TOTAL NUMBER OF DAYS REQUESTED AFTER YOU USE 10 DAYS OF SICK
LEAVE _____

If requesting more than 6 weeks, an updated medical statement will be required.

***(If you are pregnant, please list your due date. You must notify a committee member with the
exact date the baby is born before coverage will begin. You will only be granted six weeks.)***

Please read each statement carefully and place your initials in the right column to acknowledge your understanding.

I authorize the Sick Leave Bank Committee to confer with my physician in regards to the number of days required for my recuperation.	
I acknowledge that the bank may require me to obtain a second opinion before granting additional days at my own expense. While I can modify this application, a new doctor's statement will be necessary, and a second opinion may also be requested at that stage.	
I acknowledge that I need to be away from work for ten (10) days of sick leave before the bank will provide support. Once I have completed the required ten days of sick leave, I will be eligible for assistance.	
I understand that if my application is approved by the bank, I will contribute one day for every four days of support provided by the sick leave bank during the grant period.	
I understand that after I have used my ten days, if I do not have sufficient sick days or personal days to cover the requested time off, I will forfeit my pay for that day.	
I understand and have read Article 4 and Appendix A of the Negotiated Agreement and can refer to it to find more information about the sick bank and its policies. Link to Negotiated Agreement	
I understand that absences must be documented in Skyward before days can be granted.	

DATE SIGNED _____
 APPLICANT'S SIGNATURE _____

Digital signatures WILL NOT be accepted

Completed application (All three pages) can be faxed, emailed or dropped off at the district office.

Fax Completed Applications to:

(208) 235-3280

Attention: Shauna Miller/Cheryl Howell

Call (208) 232-3563 to confirm the fax was received.

Email Completed Applications to:

sickleavebank@sd25.us

School District Office Address

3115 Pole Line Road, Pocatello, Idaho

Sick Leave Bank Committee Members

Sherri Christensen - Pocatello High School, Chair

Sarah Clarkson - Highland High School

Cheryl Howell - District Office Payroll

Shauna Miller - District Office Human Resources

Mary Anne McGrory - Alameda Middle School

christs@sd25.us

clarkssa@sd25.us

howellch@sd25.us

millersh@sd25.us

mcgrorma@sd25.us

ATTENTION MEDICAL PERSONEL: Please make a copy of these documents and place them in the patient's medical file.

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 _____

No Digital Signatures

The section below must be filled out by medical professionals

Pocatello-Chubbuck 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 INJURY/ILLNESS/DIAGNOSIS 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?

Date _____

Physician's Signature (required) _____

No digital signatures