CENTRAL CONSOLIDATED SCHOOL DISTRICT
"A Community of Learners Dedicated to Building Lives"
CCSD Administration Complex • Human Resources Department
P.O. Box 1199, Shiprock, NM 87420 • 505-598-1018 Fax 598-1019

SICK LEAVE BANK PROGRAM REQUEST

PURPOSE:

The purpose of the Sick Leave Bank (SLB) Program is to provide an employee additional paid leave when he/she has exhausted their accrued leave as a result of a catastrophic illness, disability, or serious accident that requires hospitalization or home confinement beyond accumulated sick leave.

DEFINITIONS:

Sick Leave Bank: Is a leave bank where an employee will contribute one (1) paid leave day/sick leave bank, one time only unless the leave bank would become depleted. A Sick Leave Bank member may apply to the Sick Leave Bank for sick paid leave days in the event the member or a member of their immediate family (mother, father, spouse, biological, step, adopted, or foster son or daughter) suffers a catastrophic illness, disability, or serious accident.

Catastrophic Illness: A catastrophic illness is a severe illness requiring prolonged hospitalization or recovery. Examples would include coma, cancer, leukemia, heart attack, or stroke.

Disability: Illness, accident, or injury disabling an individual from preforming his/her work duties.

Serious Accident: Accident requiring extensive hospitalization and/or home care that disables an individual from performing his/her work duties.

ELIGIBILITY:

1) An employee must contribute one (1) paid leave day, one-time only, during the first thirty (30) days of initial employment or during an open enrollment period. The SLB open enrollment for existing full-time employees will be September 1 to 15, annually.

2) The applicant must be experiencing either a catastrophic illness, disability, or serious accident as defined in the CCSD Board Policy, G-3100 and the CBA, Article 11.

APPLICATION PROCESS ON HOW TO APPLY TO THE SLB (MEMBERS):

1) The employee must verify membership with the HR Benefits Office. If employee is a current member, they may apply and download the attached forms:

   - SLB Request form
   - SLB Release of Information/Physician Statement or FML Medical Certification

2) Member must have exhausted all accrued leave before submitting request to receive Sick Leave Bank Days per the CCSD Board Policy, G-3100 and CBA, Article 11.

3) The employee must submit a completed application to the HR Benefits Office. A physician statement or medical certification must accompany the request. A medical certification can be used for both a FMLA request and SLB request.

   To submit completed forms, please fax, mail, or scan and email forms to johnar@centralschools.org.

   Central Consolidated School District
   ATTN: HR Benefits Office, Arielle John
   P.O. Box 1199
   Shiprock, NM 87420
   Phone: 505-598-1018 Extension 10126
   Faxed to: (505)598-1019

4) Upon receipt of complete application, the Sick Leave Bank Committee will review all documents and will render its decision in writing within ten (10) working days. Incomplete applications will not be accepted. All information will be highly confidential. Your medical information is protected according to the HIPAA and the Privacy Act.

APPROVED / DENIED FOR SICK LEAVE BANK DAYS:

Approved:

- The HR Benefits Office will send a copy of the signed approved letter to the employee and the Payroll Department.
- Once the Sick Leave Bank days are issued, the employee and supervisor are responsible to input leave.

Denied:

- The HR Benefits Office will send a copy of the signed denied letter to the employee and the Payroll Department.
- The decision of the SLB Committee is final with no appeal.
- Members may reapply depending on determination reasons.
- The SLB Committee reserve the right to request for a second physician's option.

POLICY REFERENCED:

Central Consolidated School District Board Policy, G-3100, Professional / Support Staff Voluntary Transfer of Accrued Annual or Sick Leave

Collective Bargaining Agreement, Article 11, Sick Leave Bank – All Certified, Educational Support Professionals and Administrative Staff

QUESTIONS:

If you have any questions or need assistance with the Sick Leave Bank Program, please contact Arielle John, HR Benefit Specialist, at 505-598-1018 ext. 10126 or email johnar@centralschools.org.

CENTRAL CONSOLIDATED SCHOOL DISTRICT
SICK LEAVE BANK REQUEST

Name: _____ Job Title: _____

Work Site: _____ Date of Request: _____

Number of consecutive years you have worked for CCSD? _____

Sick Leave Bank days may only be used for the following: (Please check only one box)

☐ **CATASTROPHIC ILLNESS**
Major surgeries and/or life-threatening illness/diseases, (e.g., cancer, heart attack, stroke)

☐ **DISABILITY**
Illness, accident, or injury disabling an individual from performing his/her work duties.

☐ **SERIOUS ACCIDENT**
Accident requiring extensive hospitalization and/or home care that disables an individual from performing his/her work duties.

Number of sick leave bank days you are requesting for? _____

What are the dates you have been absent for this illness? _____

Please print a highly detailed description of the medical condition for which you are requesting sick leave bank days. (Employee's description)

_____

_____

_____

_____

_____

Have you ever requested for Sick Leave days before? ◯ Yes ◯ No

If yes, please indicate the dates and the medical condition resulting in your request.

_____

_____

_____

All questions on application must be answered. The Sick Leave Bank Committee will render a decision within ten (10) working days after receiving a completed application.

Employee Signature: _____ Date: _____

(May be signed by Power of Attorney if applicant is unable to do so.)

CENTRAL CONSOLIDATED SCHOOL DISTRICT
SICK LEAVE BANK REQUEST – RELEASE OF INFORMATION
(Must be completed by applicant)

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

I hereby authorize _____ to release information requested on this form and any information needed to the CCSD Sick Leave Bank Committee.

Signature: _____ Date: _____

PHYSICIAN'S STATEMENT

Your patient has requested for additional SLB that has been accrued. The Sick Leave Bank Committee needs the following information to determine if the employee's request is for a ***catastrophic illness, disability, or serious accident*** involving the employee.

Today's date: _____

Physician Name: _____

Physician Address: _____

Type of Practice / Medical Specialty: _____

Telephone Number: _____ Fax Number: _____

Date of onset of medical condition: _____

Please give a detailed description of the patient's illness/injury in common terms.
(**Please print clearly**.)

_____

_____

_____

_____

_____

_____

_____

Is the condition chronic in nature? ◯ Yes ◯ No

Was surgery performed? ◯ Yes ◯ No

Were there any complication medical conditions or extenuating circumstances? If yes, please explain. ◯ Yes ◯ No

_____

_____

What are the minimum days required to recover prior to returning to work? _____

When can this person return to work? _____

Will this person be able to perform their full work duties? ◯ Yes ◯ No

If no, what are his/her limitations?

_____

_____

Is modified duty possible? ◯ Yes ◯ No

If so, when can it began? _____

_____ _____

Physician's Printed Name Physician's Signature