



**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 • 505-368-4984 • Fax 505-515-0439

## **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 day; 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 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.

### **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:  
[geors@centralschools.org](mailto:geors@centralschools.org).

Central Consolidated School District  
ATTN: HR Benefits Office, Suzanna George  
P.O. Box 1199  
Shiprock, NM 87420  
Phone: 505-368-4984 ext. 10130  
Fax: (505) 515-0439

- 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) business 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.
- Employees receiving days from the Bank will be required to repay the Bank with the minimum payment of one (1) day per year until repayment of received days is complete or the employee no longer is employed by the District.

##### **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 Suzanna George, HR Specialist, at 505-515-0439 or email [geors@centralschools.org](mailto:geors@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)

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**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)

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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.

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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.)**

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Is the condition chronic in nature?	Yes	No
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Was surgery performed?	Yes	No
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Were there any complication medical conditions or extenuating circumstances? If yes, please explain.	Yes	No
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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?

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Is modified duty possible? Yes No

If so, when can it began? \_\_\_\_\_

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature