CENTRAL CONSOLIDATED SCHOOL DISTRICT # 22

Administration Complex

P.O. Box 1199, Shiprock, NM 87420

US Hwy 64 Old High School Rd

Business Office • 505-598-5834/598-9684 • Fax 598-6626

Personnel • 505-598-1018/368-4963 • Fax 598-1019

Administration • 505-368-4984 • Fax 505-368-5232

Sick Leave Bank Packet

Definitions

Sick Leave Bank – a bank whereby each employee, on a voluntary basis, may contribute one (1) paid leave day to the Bank and become a member. A Bank member may apply to the Bank for paid leave days in the event the member *or a member of his/her immediate family (mother, father, spouse, biological-, step-, adopted-, or foster son or daughter)* suffers a catastrophic illness, disability, or serious accident and has exhausted all accumulated sick leave.

Catastrophic Illness – major surgeries and/or life threatening illnesses/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.

As per CCSD Board Policy G-3100:

All accrued leave, must be used before an employee is eligible to receive days from the bank.

The SLBC will meet to review your application after all accrued sick leave, paid leave, personal leave, and /or vacation leave has been exhausted.

Return all <u>original</u> completed forms to
Central Consolidated School District No. 22
Shiprock Administration Complex Bldg B
P.O. Box 1199
Shiprock, NM 87420

Fax copies must have the original follow either mailed or hand delivered.

MEDICAL FORMS MAY BE USED FOR BOTH FML REQUEST OR/AND SLB REQUEST

Authorization to Review Previous Sick/Personal/Emergency Leave

I hereby authorize CCSD to release information related to use of my past sick leave to the Sick Leave Bank Committee. I also authorize the committee to discuss the use of this leave with current and former supervisors.

Applicant Signature: _____

Location: _____

Date: _____

Please provide the following information so that SLBC may respond to your request for leave. It is important that you provide the address and telephone number where we can find you during your absent and/or recovery.

Address: _____

_____

_____

Phone: _____

Central Consolidated School District No. 22
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 works 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? _____

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)

_____

_____

_____

_____

Please give a brief description of the way you have used your sick leave days.

_____

_____

_____

_____

Have you ever requested 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) workdays, after receiving a completed application.

Employee Print Name: _____

Employee Signature: _____ Date: _____

(May be signed by next of kin if applicant is unable to do so)

Central Consolidated School District No. 22

Sick Leave Bank Request – Release of Information

(Must be completed by physician)

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 petitioned the Sick Leave Bank of Central Consolidated Schools for additional sick leave that has been accrued. Granting the request could amount to several thousand dollars worth of benefits. The Sick Leave Bank 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: _____

Date of onset of medical condition: _____

Please give a detailed description of the patient's illness/injury in laymen's terms.
(Please type or print legibly).

_____

_____

_____

_____

_____

_____

Is this condition chronic in nature? Yes No

Was surgery performed? Yes No

Was surgery recommended by the physician to be preformed as soon as possible? Yes No

Could the surgery be performed at more convenient time for the employee i.e. spring break, summer months? Yes No

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

_____

_____

What is the normal recovery period for this particular condition?

_____

_____

How much time is needed for the person to fully recover? _____

What are the minimum days required to convalescence 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 begin? _____

What is the patient's status? _____

_____

Prognosis: Good Fair Poor

_____ _____
Physician's Print Name Physician's Signature