EMPLOYEE SICK LEAVE BANK

REQUEST FOR SICK LEAVE BANK DAYS

General Information

Name:_______________________

Position: Campus/Work Location:_________________________

Date of Employment: Supervisor:_________________________

Work Phone: ___________________Home Phone:___________________

Request for Sick Leave Bank (SLB) Days

Number of days requested from SLB (increments of 10 up to 30 days) and

Dates Requested:____

Reason for request *(Fully describe personal injury or illness for which leave days are requested.)*

____
____
____
____

First date absent for this condition: ______________

Total number of days absent for this condition:__________________________

Date state and local leave exhausted:________________________

Did this absence result from a condition that you were aware of on the date you joined the SLB?

Yes No

Have you received any other SLB days this school year? Yes No

If yes, state number of days, dates received and condition for which you received a grant of SLB days:____
____

Did this absence result from an injury or illness sustained during the course and scope of your employment with AISD?

Yes No

If yes, state the date of the incident:

____

Are you receiving any workers' compensation benefits for this injury or illness? Yes No

If yes describe, the benefits you are receiving:___________________________________

Employee Certification

I certify that the foregoing information is correct. I understand that the falsification of any information submitted to the SLB Committee or my failure or refusal to promptly provide any information requested by the SLB Committee may delay benefits provided to me or disqualify me for benefits and result in the revocation of my membership in the AISD SLB.

Signature: ____________________

Date Signed:__________________

SUBMIT COMPLETED REQUEST FORM TO THE DIRECTOR OF HUMAN RESOURCES

EMPLOYEE SICK LEAVE BANK

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _________________

I authorize you, as my attending physician, to release all requested medical information and records about me to a representative of the AISD Sick Leave Bank Committee.

Patient's Signature: ____________________Date Signed:_____________________

PHYSICIAN'S STATEMENT *(This form must be fully completed.)*

1. Are you the regular health care provider for this patient? Yes No

2. Is this patient presently under your care? Yes No

3. Describe the illness, injury, or condition for which you are treating this patient.

____

____

____

____

4. Date(s) of treatment:

____

5. To your knowledge, what is the earliest date this patient was treated for the above illness, injury, or condition?

____

6. Date(s) of incapacity to work due to the above illness, injury, or condition:

____

7. Date on which patient is expected to be released to return to work:

____

8. Anticipated date(s) of follow up examination or treatment for the above illness, injury, or condition:

____

9. If patient was hospitalized for the above illness, injury or condition:

a. Date(s) of hospitalization:____

b. Name of hospital:____

Physician/Health Care Provider's Name Physician/Health Care Provider's Address:

____

Physician/Health Care Provider's Telephone Number Name of Contact Person:

____

Physician/Health Care Provider's Signature __________________________

Date Signed:________________________

Please return this form to:

Director of Human Resources
Aledo Independent School District
1008 Bailey Ranch Road
Aledo, Texas 76008
(817) 441-8327
staylor@aledoisd.org