HUMAN RESOURCES DEPARTMENT
16717 ELLA BLVD. ▯ HOUSTON, TEXAS 77090 ▯ 281-891-6040 TEL ▯ 281-891-6041 FAX

# CATASTROPHIC SICK LEAVE BANK REQUEST FORM – STAFF MEMBER

| **Staff Member's Last Name** | **First Name** | **Middle Initial** |
|---|---|---|
| | | |

| **Employee ID #** | **Date of Birth (mm/dd/yyyy)** |
|---|---|
| | |

| **School/Department & Position** | **Date of Request (mm/dd/yyyy)** |
|---|---|
| | |

## DAYS ABSENT CURRENT SCHOOL YEAR

| | |
|---|---|
| 1. First day of absence due to this illness this school year: | Date: _____ (m/dd/yyyy) |
| 2. Total number sick leave days used related to this illness this school year: | Total: _____(sick days) |
| 3. Total days absent due to this illness: | Total: _____ (days absent) |
| 4. Last day of sick leave: | Date: _____(mm/dd/yyyy) |
| 5. Will be eligible to draw disability insurance on: | Date: _____(mm/dd/yyyy) |
| 6. Did you enroll in a disability insurance plan: | _____ Yes _____ No |

## REASON FOR REQUESTING CATASTROPHIC SICK LEAVE BANK DAYS

The above requested days are needed for the reason of personal illness or injury as described:

_____(initial) I have used all of my available state and local sick leave and accrued vacation, if applicable, for this year. I am not eligible to receive Worker's Compensation insurance payments nor disability insurance for my current condition for which I am absent from work.

____initial) I have donated the required day(s) of my local sick leave to the Catastrophic Sick Leave Bank and am a member of the CSLB eligible to receive the benefits of the Bank.

_____(initial) A completed statement from my physician is attached.

_____ _____

Staff Member's Signature Date

**PLEASE COMPLETE AND RETURN ALONG WITH PHYSICIAN'S STATEMENT TO SPRING ISD – BENEFITS OFFICE**

spring ISD
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# CATASTROPHIC SICK LEAVE BANK
# ATTENDING PHYSICIAN'S STATEMENT

| **Patient's Last Name** | **First Name** | **Middle Initial** |
|---|---|---|
| **Social Security Number** | **Date of Birth (mm/dd/yyyy)** | |
| **School/Department** | **Position** | |
| Authorization to release information for purpose of determining eligibility for benefits, I hereby authorize Spring Independent School District Catastrophic Sick Leave Bank to receive from and/or provide to medical practitioners, medically related facilities, insurance companies, or my employer, information as to any physical or mental condition of myself relating to this claim. I know that I have a right to receive a copy of this authorization. I agree a photographic copy is as valid as the original. | | |
| **Staff Member's Signature** | **Phone Number** | **Date** |

## PRESENT CONDITION

Describe in lay terms the nature of illness or injury:

_____

_____

_____

_____

Is condition due to a pregnancy? _____ Yes _____ No

Has patient had similar condition in the past? ? _____ Yes _____ No
If "yes", state when and describe:

_____

_____

## DIAGNOSIS

Explain the short-term prognosis:

_____

_____

Explain the long-term prognosis:

_____

_____

| | | | | | | |
|---|---|---|---|---|---|---|
| Would you categorize this person's illness as terminal or life threatening? | | Terminal | | Life | | Neither |

## TREATMENT

To your knowledge, what is the earliest date this patient was treated for this condition? _____

Give dates of treatments:

_____

_____

List all hospitalizations:

| Hospital | Address | Date Admitted | Date Discharged |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Is patient still under your care? _____ Yes _____ No

## EXTENT OF ILLNESS OR INJURY

As you understand the patient's job responsibilities with SISD, from your professional assessment of the patient's current condition, can you recommend this person to return to work at this time to perform the regular job assignment?

_____ Yes _____ No

| | |
|---|---|
| How long was or will patient be unable to work? | Length: _____ (wk, mo, yr) |
| Anticipated date patient can return to work? | Date: _____ (mm/dd/yyyy) |

| | |
|---|---|
| **Printed Name of Attending Physician** | **Date** |
| **Signature of Attending Physician** | **Type of Practice** |
| **Address** | **Telephone number** |

**THIS FORM SHOULD BE RETURNED TO THE PATIENT**