Miller County School District

SICK BANK FORM INSTRUCTIONS

1. Employee completes Sick Bank Request Form.
2. Doctor completes Sick Bank Physician's Statement.
3. Send forms to:

Lisa Spooner, Payroll/Benefits Coordinator
Miller County School District
96 Perry Street
Colquitt, GA 39837

Please Note:

The Sick Bank Committee will only consider approval for sick bank days from the time that the request was received. You must have your doctor fill out a Sick Bank Physician's Statement.

Miller County School District

SICK BANK REQUEST FORM

Name: _____ Unit: _____

Address: _____

_____

School or Department: _____

Home Phone: _____ School Phone: _____

REQUEST

Start Date*: _____ End Date: _____

Estimated Return to Work Date: _____

Attending Physician: _____

I have attached my Physician's statement. _____Yes _____No

Comments:_____

_____

***The Sick Bank Committee will only consider approval for sick bank days from the time that the request was received.**

_____ _____

Member Signature Date

DECISION ***(for office use only)***

Request Approved: _____ _____

Superintendent's Signature *Date*

Number of Days Approved: _____ A Physician's statement has been received_____

Dates beginning: _____ through _____

Comments:

_____

Request Denied: _____ _____

Superintendent's Signature *Date*

If denied, reason denied:

_____

___ ***copy to Payroll/Benefits***

___ ***approval sent to member's home***

Miller County School District

SICK BANK PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PATIENT

Name: _____ Unit: _____

Address: _____

_____

School or Department:

_____

Home Phone: _____ School Phone: _____

_____ _____

Member Signature Date

TO BE COMPLETED BY PHYSICIAN

Brief description of disability - if applicable, indicate due date and/or delivery date (layman's terms please): _____

_____

If pregnant, state anticipated delivery date: _____

If still disabled, date patient should be able to return to work: _____

Patient was under my care and unable to work beginning _____ through _____

Physician's Name (please print): _____

Business Phone: _____

Address: _____

_____

_____ _____

Physician's Signature Date

PLEASE RETURN TO PATIENT FOR SUBMISSION WITH SICK BANK REQUEST FORM