RHEA COUNTY SCHOOLS
SICK LEAVE BANK REQUEST FORM

DATE ____________________

SECTION A – TO BE COMPLETED BY EMPLOYEE (PRINT OR TYPE):

Name ________________________________ Social Security No. ______________

School _________________________ Position _____________________________

Home Address ____

Telephone: Home __________________ Work __________________

Is this injury/illness work related? ______ Yes _____ No

Date of Last Day Worked ________________ Number of Days Requested ______

Accumulated to Date: Vacation Days______ Sick Leave Days ______

Describe the nature of your catastrophic illness: _____________________________

____

1. The Sick Leave Bank is available to a member with a catastrophic illness or disability causing absence from work for an extended period of time.
2. The member must have been absent, due to catastrophic illness or disability, at least five (5) working days following the exhaustion of all available paid leave.
3. The maximum number of days any member may apply for is twenty (20) consecutive days. The maximum number of days a participant may receive in a fiscal year (July 1 – June 30) is sixty (60). The maximum number of days a participant may receive as a result of any one illness or accident is ninety (90).
4. All leave granted but not used will be returned to the Sick Leave Bank.
5. Physician's Name ____________________________ Phone _______________

   Address____
6. *I authorize my physicians to release information relating to my catastrophic illness or disability to the Rhea County School System's Sick Leave Bank:*

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Signature of Employee or Designee

SECTION B – TO BE COMPLETED BY SICK LEAVE BANK COMMITTEE:

Employee’s Name ____

Date Request Received _____________ Physician’s Statement Attached ___Yes___No

Member’s Accumulated Leave Ends/Ended __________________

First Day of Work Missed For This Illness ___________________

Request Granted _________Number of Days Granted From Sick Leave Bank_________

Request Denied __________ Reason Denied _________________________________

____
Signature of Sick Leave Bank Committee Member

RHEA COUNTY SCHOOLS
PHYSICIAN'S FORM FOR VERIFYING
CATASTROPHIC ILLNESS OR DISABILITY OF EMPLOYEE

Name ____ SSN _________________
Last First MI

School _________________________________ Work Phone ______________________

Address ____
Street Address

____
City State Zip Code

PHYSICIAN'S REPORT OF CATASTROPHIC ILLNESS

____
____
____
____
____
____

Disability Begins _______________ Estimated Date Disability Ends ________________

Physician's Name ___________________________________ Phone Number _________

Address ____
Street Address

____
City State Zip Code

I certify that the above named employee is under my care and will be unable to perform normal duties during this period. Adjustments in these dates may be necessary at a later date.

___________________________________ Date ___________________
Physician's Signature