Sick Leave Bank Request

Procedure and Doctor Authorization Form

To apply for sick bank days, please submit the ***Request for Sick Bank Application*** for review by the committee and have your physician complete the ***Dr. Authorization Form***. This form must be submitted with the Sick Bank application.

Incomplete applications will be returned to you without consideration.

Your application must adhere to the rules and regulations for the SCEA Sick Bank.

St. Charles Education Association Sick Leave Bank Rules and Regulations Revised 2010

The intent of this plan is to provide extended sick leave to those educators who incur a period of personal serious and/or prolonged illness or hospitalization and who have used all of their personal sick leave.

Section 1: Regulations defined by the Professional Agreement (section 15.10 -- Sick Leave Bank)

1. **The educator shall have exhausted his/her individual accumulated sick leave.**
2. **The maximum days awarded on an illness or injury shall be ninety (90) days. The use of the sick leave bank is for the employee only.**
3. **The first thirty (30) consecutive school days of illness or disability will not be covered by the bank, but must be covered by the person's own accumulated sick leave, or absence without pay.**
4. **The Sick Bank Committee reserves the right to require an additional doctor's examination with a doctor of the Sick Bank Committee's choice, who is a part of the member's insurance plan, prior to awarding sick days, at the member's expense.**
5. **The Sick Bank Committee will award days in increments of no more than thirty (30) at a time per member. Members who require more than thirty (30) days from the sick bank will be required to submit verifications as requested by the Sick Bank Committee.**

Your balance of sick/personal days is available on Employee Access. If you have other questions regarding your sick/personal days, you can contact the District's Human Resource Department.

Send your ***Request for Sick Bank Application*** and ***completed Doctor Authorization Form*** to: Human Resources at District Office.

Please contact Shari Hayes, chair of the Sick Bank Committee, at St. Charles North High School if you have any questions, 331-228-6272.

SICK BANK REQUEST

Please complete this form and submit it to the Human Resources Department. Refer to SCEA Professional Agreement, section 15.10, for Sick Leave Bank Eligibility and procedures.

Member's Name: _____ Date: _____

Primary Work Location: _____ Position: _____

Reason for Request: _____

☐ **Continuous block of time** (Several Continuous days, weeks or months)

Estimated Leave Start Date: _____ Estimate Leave End Date: _____

☐ **Intermittent basis** (Periodic time off for ongoing treatment/appointments)

Estimated Leave Start Date: _____ Estimate Leave End Date: _____

☐ **Pregnancy (**Request for days postpartum should be made after postpartum doctor's appointment)

☐ Medically unable to work due to: _____ Expected delivery date: _____

Actual delivery date: _____

Number of Sick/Personal Days remaining prior to medical absence: _____

Number of days requesting from the Sick Bank: _____

The original, completed and signed Doctor Authorization Form must be submitted with the sick bank applicati

_____ _____

Employee Signature Date

Do not Write Below this line

_____ _____

HR Signature Date

_____ _____

SCEA Sick Bank Signature Date

Human Resources Department

Total # of Days Absent: _____

 # Paid Sick Days _____

 # Unpaid Sick Days _____

Date Eligible for Sick Bank Pay: (after 30 consecutive work days absent and exhausted all accumulated sick leave)

_____

SCEA Sick Bank Committee

# of Sick Days Approved: _____

2/25

Doctor Authorization Form

Our member/employee has applied for SCEA Sick Bank extended medical leave. We need verification to determine that the employee is medically unable to work and eligible for time off that is fully paid by the school district by means of sick days donated by the district's teachers. Please complete the information below and return to the member/employee. We appreciate your prompt attention and cooperation. Thank you!

I authorize release of the following information to my employer and the SCEA Sick Bank Committee.

_____

Patient (Employee) Signature

For completion by physician or physician's staff ONLY! Must be an original; copies not accepted.

Patient Name: _____ Date of Evaluation: _____

Physician Name: _____ Phone Number: _____

Practice Name: _____

Address: _____

Diagnosis/nature of illness or injury: _____

_____

Recommended limitations on patient's ability to work: _____

_____

_____

Patient's time off begins (date): _____

Anticipated date patient may return to work: _____

Next scheduled medical evaluation: _____