Bakersfield City School District

Catastrophic Illness Sick Leave Bank Recipient Application Form

Please type or print in ink.

Employee: ____ EIN: ____________________

I am requesting a withdrawal from the Catastrophic Illness Sick Leave Bank for the following time period:

From: ______________________________ Through: ____________________________

Reason for Request:

____ Catastrophic illness for employee

____ Catastrophic illness for eligible family member*

*Relationship of family member, if applicable: ____

Please attach a written verification, prepared and signed by a licensed physician of the State of California, certifying that the catastrophic illness or injury is one that incapacitates you for an extended period of time, or that incapacitates a member of your family and requires you to take time off from work to care for that family member. The written verification must include the anticipated duration of the leave. You may also attach any other documentation you wish the committee to consider. Please return this completed form and any additional information to the Bakersfield City School District Human Resources Department at 1300 Baker St. Bakersfield, CA 93305.

I understand the terms and conditions of the Catastrophic Illness Sick Leave Bank program. I further understand that I may be required to undergo an examination by a physician selected from a list supplied by the District, at the District's expense, to verify the catastrophic injury or illness.

____ ________________________

(Employee Signature) (Date)

For CLB Governing Committee Use Only

Approved: Yes_____ No ____ From: ___________________ Through: _________________________

Total number of days approved: ______________

If no, reason ____

(1) _____________________________________ (2) _______________________________________

(3)______________________________________ (4) _______________________________________

(5) _____________________________________ Date: ______________________________ 7/22