

SICK LEAVE BANK INSTRUCTION SHEET

Only persons who are members of the Sick Leave Bank may apply. Sick Leave bank awards are based upon medical necessity and eligibility.

Make sure this application is complete. Your health care provider **MUST** include a “diagnosis, treatment plan, and estimated return to work date”.

Only original signatures from physicians -- M.D., D.O., D.P.M. -- will be accepted on applications. A licensed nurse practitioner may sign on sick leave bank requests but not on catastrophic leave bank requests. A diagnosis of mental or emotional illness must be accompanied by a psychiatrist’s signature.

If this illness or injury is work related, you may be eligible for Workers’ Compensation. If eligible, you **MAY NOT** apply to the Sick Leave Bank.

AEA MEMBERS ONLY

A false statement by the AEA member regarding sick leave is sufficient grounds for cancellation of the contract and recommendation for revocation of the teaching certificate. (Per AEA/ASD negotiated agreement Article #345-J)

Medical procedures which are elective in nature or that can reasonably occur outside the AEA member’s normal work schedule are not eligible for Sick Leave Bank awards.

Part A: To Be Completed by Applicant		Check the type of leave you are applying for: <input type="checkbox"/> Sick Leave Bank Request <input type="checkbox"/> Catastrophic Leave Bank Request	
(Please Print) Last Name		First Name	SS#
Mailing Address		Home Phone	Job Title/Work Location
Incomplete information will lead to the denial of a sick leave bank award. * Have you been off work at least five (5) consecutive working days? <input type="checkbox"/> Yes <input type="checkbox"/> No * Is this a job related illness? <input type="checkbox"/> Yes <input type="checkbox"/> No * Will Workers' Compensation Benefits be applied for? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Applicant's Signature			Date
Part B: To Be Completed by Physician <u>This employee is soliciting a leave award from co-workers.</u> Please complete the following information. Be as specific as possible. <p style="text-align: center;">Nature of Illness: If you need more space, attach an additional sheet.</p> Medical Diagnosis (<i>Diagnosis of Emotional or Mental Illness must be completed by a psychiatrist/psychiatric nurse practitioner.</i>)			
Treatment Plan: (<i>Explain regimen of treatment prescribed indicating number of visits, nature and duration of treatment, prognosis, # of follow-up visits and nature of treatments. Will the employee need to be off work on an intermittent basis or work a reduced work schedule? If yes, please explain.</i>)			
ICD.9 Code: _____ If maternity, state the date of birth: _____ Type of Delivery: Vaginal <input type="checkbox"/> Cesarean Section <input type="checkbox"/> If not maternity, date condition commenced: _____ Length of time patient is medically unable to work: _____ Is employee able to perform work of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No Is medical procedure elective? <input type="checkbox"/> Yes <input type="checkbox"/> No Is in-patient hospitalization required? <input type="checkbox"/> Yes <input type="checkbox"/> No Is prescribed treatment/surgery urgent-emergent? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No" can the recommended procedure reasonably occur between June 1 and mid-August? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Beginning Date of Illness		Date Patient Able to Return to Work	
<i>Teaching may be considered light duty within the scope of workforce definitions. There are limited requirements for bending, standing, walking and lifting up to 10 pounds and occasionally 40 pounds. There may also be requirements for monitoring students in an outside environment for up to 30 minute time periods. By completing and signing this form you are attesting to the fact that the patient/employee listed above is unable to perform the above job functions and that there is a medical necessity for the patient/employee to be absent from work.</i>			
Physician/Nurse Practitioner Signature(s) and Title (ONLY)			Date
IRS Number	Physician/Nurse Practitioner Name (PRINTED)		Telephone No.