Sick Leave Bank Application Process

◊ Request the following forms by contacting Melinda Buckingham, Risk Management 352-726-1931 ext 2283

Sick Leave Bank Withdrawal- Application
Sick Leave Bank Withdrawal-Physician's Statement

◊ The sick bank member completes Sick Leave Withdrawal Application
◊ The sick bank member completes the Medical Information Release on the Physician's statement
◊ The treating physician completes the Physician's Statement

Incomplete forms will be not be processed.

◊ The physician's office faxes the medical statement directly to Melinda Buckingham at 352-249-2125 or it can be e-mailed to buckinghamm@citrus.k12.fl.us

An updated physician's Statement must be completed for each additional 20 day request.

The completed application and physician's statement will be submitted to the Sick Leave Bank Committee for consideration.

Additional Information or clarification may be requested by the committee from the physician or sick leave bank member.

Prior to submitting your application, you must meet the following criteria:

All accrued leave sick/personal/vacation is exhausted_____

You will be out on unpaid medical leave for a minimum of 10 consecutive work days by order of a physician_____

The Risk Management Department will notify you of the committee's decision.

The purpose of the Sick Leave Bank is to provide eligible employees who have exhausted all of their accumulated paid leave and would otherwise be on unpaid leave status, the means of obtaining additional paid sick days upon proper approval. This leave is for unplanned personal catastrophic illness or injury. The Sick Leave Bank allows eligible employees time to be restored to health so that they may return to work. It is not the intent of the Sick Leave Bank to provide additional days off for elective surgery, or to be used in lieu of a health leave or prior to retirement or resignation.

CITRUS COUNTY SICK LEAVE BANK PROGRAM

SICK LEAVE WITHDRAWAL APPLICATION

NOTE: THE FOLLOWING IS TO BE COMPLETED BY THE SICK BANK MEMBER:

Incomplete forms will not be processed

EMPLOYEE'S NAME:_____
PRINT

EMPLOYEE ID NUMBER:_____

MAILING ADDRESS:_____

PHONE NUMBER:_____E-MAIL_____

WORK LOCATION:_____POSITION:_____

I understand that: The purpose of the Sick Leave Bank is to provide eligible employees who have exhausted all of their accumulated paid leave and would otherwise be on unpaid leave status, the means of obtaining additional paid sick days upon proper approval. This leave is for unplanned personal catastrophic illness or injury. The Sick Leave Bank allows eligible employees time to be restored to health so that they may return to work. It is not the intent of the Sick Leave Bank to provide additional days off for elective surgery, or to be used in lieu of a health leave or prior to retirement or resignation._____please initial

I have exhausted all of my sick/personal and vacation days as of _____.

I am applying to the Sick Leave Bank for the following medical reason(s):_____
_____
_____
_____

It is my intent to return to work _____YES_____NO

Estimate the beginning and ending dates for the period of incapacity_____to_____.

Please explain why treatment cannot be postponed to a non-work period:
_____
_____
_____

I certify/understand that:

- ☐ I have been____ OR will be____ out on unpaid medical leave for a minimum of 10 consecutive work-days by order of my Physician.
- ☐ I am requesting to withdraw days from the Sick Leave Bank. I understand that payment will be made in the pay period following approval of the application by the Sick Leave Bank Committee.
- ☐ An updated Physicians Statement must be submitted for each additional 20 day request.
- ☐ No employee shall be eligible to draw more than sixty (60) days from the pool for any one illness or injury or complications thereof.

☐ Have you ever been approved for sick leave bank withdraw? ___Yes* ___No

*If Yes, how many days were you awarded?_____
In what year?_____For what reason?_____

☐ Per Policy: CITRUS 6.911G

VI. Abuse of Sick Leave Bank: If an employee is found to have abused the use of the sick leave bank, the employee shall repay all of the sick leave credit drawn from the bank and be subject to such other disciplinary action as determined appropriate by the School Board. Investigation of alleged abuse shall be made by the Superintendent or his designee.

I hereby certify the above information to be true and correct. I am attaching the Sick Leave Bank Withdraw Physicians Statement to verify this information. I hereby grant the Sick Leave Bank Committee permission to speak with my Physician about my medical condition, if the Committee needs more detailed information. I understand and agree that the decision to award days from the Sick Leave Bank is at the sole discretion of the Sick Leave Bank Committee and is final and binding.

Signature of Employee Date

Citrus County School Board-Sick Leave Bank Physician's Statement-Page 1 of 2

This form is to be completed by the attending physician

Memo to Physician:

The employee requesting this statement is applying to the Citrus County school Board's Sick Leave Bank which is self-funded by participating members to assist their peers in times of need. Benefits from the SLB are available to members who have exhausted all accumulated leave and are experiencing a serious/catastrophic illness or injury. Incomplete applications will not be processed until all sections are completed in full. Medical verification of current condition will be requested for each 20 days of leave.

This section to be completed by Employee

MEDICAL INFORMATION RELEASE

Employee/Patient's Name:_____Employee I.D. #_____

I hereby authorize the physician named above to release any information needed by the Citrus County School Board Sick Leave Bank Committee.

Employee Signature:_____ Date:_____

MEDICAL CERTIFICATION (to be completed by the attending physician)

Please complete the following information regarding the patient named above.

Patient Name:_____

Currently being treated for:_____

Describe the illness or injury:

_____

_____

_____

Explain the short term diagnosis/treatment:

_____

_____

_____

Explain the long term diagnosis/treatment:

_____

_____

_____

_____

Citrus County School Board-Sick Leave Bank Physician's Statement-

This form is to be completed by the attending physician

The condition is due to an accident_____illness_____ Please describe:

_____

_____

_____

___

Are there secondary conditions contributing to their inability to work?

What are the restrictions/limitations that prohibit this employee from working?

Please estimate the beginning and end dates for the period of incapacity:
From_____To_____

Please explain why treatment cannot be postponed to a non-work period:

_____

_____

_____

___

Was this patient hospitalized for the current condition? Is yes, how long?_____

_____I hereby certify that this leave is medically necessary to occur during the patient's regular contract days and could not be scheduled to avoid missed time from work.

Signature of Physician: _____ Date:_____

Printed Name of Physician:_____ Telephone Number:_____

Address:_____

Email:_____ Fax:_____

Please return this medical certification directly to:

Melinda Buckingham , Risk Management

Citrus County School Board, 1007 W. Main St., Inverness, FL 34450

352-726-1931 extension 2283 buckinghamm@citrus.k12.fl.us

Fax# 352-249-2125