

REQUEST
FOR USE OF
SICK LEAVE BANK

REVISED
7/17

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SICK LEAVE BANK

REQUEST #

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PART I

INSTRUCTIONS TO PARTICIPATING SICK BANK MEMBER (Educational Staff)

- 1) Complete and sign Part I (type or print legibly).
- 2) Forward to Attending Physician to complete Part II.
- 3) Submit both copies of completed original form along with a copy of your most recent payroll check stub, to the Sick Leave Bank Committee, 2512 North Charles Street Baltimore, Md 21218
- 4) We are not responsible for lateness or illegible forms. Applications received after the committee has met will be reviewed at the next scheduled Sick Bank meeting.
- 5) Faxed forms are not acceptable. (This includes any / all electronic files, emails, jpegs, text, and etc.)

Applicant Name: _____

Applicant Address: _____ City _____ State _____ Zip: _____

Email Address: _____

Phone: _____ Employee ID#: _____

Yrs. of Active Service: _____ Payroll Location: _____

Location Previous Two (2) Years: _____

Previous Illnesses in Excess of Five (5) days:
(additional sheet may be attached if needed. If none, please indicate.)

Dates	Nature of Illness
_____	_____

I request to borrow _____ days from the Sick Leave Bank.

Falsification and/or distortion of information on the application will result in automatic denial of Sick Bank grants.

Signature: _____ Date: _____

PART II

THIS SECTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN ONLY.

- 1) *Please type or print legibly. Illegible applications may not be approved.*
- 2) Treatment plan **MUST** be included with each illness.
- 3) Maternity disability period not to exceed ten weeks, includes time before and/or after the delivery of the child.
- 4) Attach additional sheets if necessary.

Nature of Illness and prognosis _____

First day Employee is unable to work _____ Return to work date _____

Physician's Name: _____ Phone: _____

Physician's Address: _____ City _____ State _____ Zip: _____

Signature: _____ Date: _____

PART III

SICK LEAVE BANK COMMITTEE ONLY

Days requested _____ Number of Days Granted _____

First day employee is unable to work _____

Return to work date _____

APPROVED _____

DENIED _____

Authorized Signature: _____ Date: _____