BENEFITS DEPARTMENT

benefits@gccisd.net
Office:(281) 707 - 3236 • Fax: (346) 216 - 3000

SICK LEAVE BANK REQUEST FORM

EMPLOYEE SECTION

Employee ID: _____ Position: _____

Last Name: _____ First Name: _____ Middle Initial: ____

If not for employee, list family member name and relationship below:

Last Name: _____ First Name: _____ Middle Initial: ____

Relationship: _____ If child, please provide age: _____

Authorization to Release Information

Authorization to release information for purpose of determining eligibility for benefits. I hereby authorize the Goose Creek CISD Sick Leave Bank to receive from and/or provide medical practitioners, medically related facilities, insurance companies, or my employer, information as to any physical or mental condition of myself relating to this claim. I acknowledge that I have read this authorization and agree to the terms.

EMPLOYEE ACKNOWLEDGEMENT

I acknowledge that I have used all my available state, local, sick and vacation days (if applicable), for this school year. I am not eligible to receive Worker's Compensation Benefits due to my absence. I have applied for FMLA or TDL for this absence. I have not applied for Short-term disability.

_____ _____

Employee Signature Date

PHYSICIAN'S STATEMENT

Specific injury or diagnosis: _____

_____

Explain prognosis, treatment and/or surgery per diagnosis: _____

_____

Would this injury/illness prevent the employee from performing the essential functions of their job? _____ Yes _____ No

Timeframe for treating this condition: (Start and End Date) _____

Was the employee hospitalized? _____ Yes _____ No

If hospitalized give dates, name and address of hospital below:

Name of hospital: _____ Date Admitted: _____

Address of hospital: _____ Date Discharged: _____

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Is this procedure medically necessary during the school year? _____ Yes _____ No

If procedure can be postponed to a later date, please specify projected time frame: _____

Can the employee return to work? _____ With Restrictions _____ Without Restrictions

If employee has restrictions, please list: _____

_____

How long will patient/employee be unable to work? _____

Anticipated date patient/employee can return to work? _____

Date: _____

_____
Signature of Physician

_____
Type or Print Physician's Name

_____
Address

_____
City State Zip

_____
Phone Number

COMMITTEE USE ONLY

_____ Approved _____ Number of days approved

_____ Insufficient documentation submitted. Please resubmit attached forms.

_____ Not Approved due to the following reason(s): _____

_____ Your physician's statement does not designate your illness as catastrophic.

_____ The nature of your illness / surgery does not meet the criteria of the diagnosis-related groups as outlined in the Sick Leave Bank Policy.

_____ You have been granted the maximum number of days allowed (60 days per plan year) per the Sick Leave Bank Policy.

Chairperson Signature _____ Date _____