Frederick County Public Schools

Request for Leave from the Educational Support Employees Sick Leave Bank

Return Fax: 301-662-9205

Employees must be a member of the Sick Leave Bank and meet the requirements as stated in the Membership Rules and Procedures (Appendix 1 of the Support Employee Negotiated Agreement). **Members must have the Physician Section of this form completed prior to submitting it to the committee.**

Employee Information Section: Employee ID#: _____

_____ _____
(Last Name) (First Name and Middle Initial)

_____
(Home Address and Zip Code)

_____ _____
(Work Location and Work Phone Number) (Home Phone Number)

_____ _____ 10 Mo. 12 Mo.
(Job Title) (Number of Hours Worked Per Week) (Months Worked Per Year)

_____ _____
(Date Employee's Sick Leave Expires/Expired) (Number of Days Requested)

_____ _____
(Approximate Date Last Received Leave from the Bank) (Was this absence reported as a work-related injury?)

_____ _____
(Employee/Patient Signature) (Date Signed)

Release: By my signature above, I hereby authorize my health care provider(s) to release any information acquired in the course of my treatment, examination, or upon review of my medical records.

Section for Health Care Provider's Statement (Please print or type)

Note: Please provide the information requested below and return the form to your patient. The Bank is charged with granting sick leave to employees who have exhausted their own leave due to prolonged, incapacitating, and catastrophic injuries or illnesses. The leave being granted is donated by other employees participating in the leave pool. Your detailed lay explanation of the patient's condition is greatly appreciated.

Diagnosis and Course of Treatment:

Extent of Incapacitation:

Name and Date of any Surgical Procedure Performed:

Date when patient became Incapacitated: _____

Date when patient will be able to return to work: _____

Is this employee permanently restricted from performing the essential functions of their job?: _____

_____ _____
(Physician's Printed Name and Signature) (Physician's Phone Number)

_____
(Physician's Address)

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