



Birdville Independent School District

Request for Sick Bank Leave Days

Employee to complete

Name: _____ Employee ID #: _____

Occupation: _____ Campus/Dept ID #: _____

Date Employed: _____ Day Phone #: _____

Date Joined Sick Bank: _____ Email: _____

Reason for Requesting Sick Bank Leave Days: I have (or will have) used all my available leave days.

Number of days requesting from the Bank _____

First date of treatment for this absence _____

Sick Bank days should begin _____

Do you anticipate any additional days to be needed for follow-up examinations or treatments?

Yes _____ No _____

Do you have an open Workers Comp claim for the above request?

Yes _____ No _____

The above requested days are needed for the reason of personal catastrophic illness as described in the attached physician's statement. I hereby authorize the Sick Leave Bank Governing Board to obtain further information pertaining to this request from my attending physician.

Yes _____ No _____

Do you authorize the release of your FML paperwork in lieu of the Sick Bank Physician's Statement?

Yes _____ No _____

Please complete and return to the Benefits Office.

Fax #: 817.547.5580

Email: erin.griffin@birdvilleschools.net

Signature

Home Phone Number

Home Address/State/Zip



TO THE ATTENDING PHYSICIAN:

RE: Employee/Patient Name: _____

Employee/Patient Date of Birth: _____

Date of Request: _____

Your patient is requesting extended sick leave benefits from the Birdville Independent School District that will afford the patient full payment for up to 30 days of sick leave in the event they are not able to work due to a catastrophic illness or injury.

Prior to approving any payment for days lost, a doctor's statement is required concerning the patient's illness.

Please provide the following information:

1. Identification of the nature of the illness and/or extent of injury as fully as possible (preferably in layman's language).
2. First date of treatment for this illness or injury.
3. Anticipated date employee will be released to return to work and whether return to work may be on a full time or part time basis.
4. Anticipated days, if any, that might be needed for follow-up examinations or treatment.

Correspondence should be addressed to:

Steven Franks
Director of Business
Birdville ISD
6125 E Belknap Street
Haltom City, TX 76117
Office: 817-547-5782
Fax: 817-547-5580

Birdville Independent School District
Employee Sick Leave Bank

Attending Physician's Statement

Patient's Name: _____

Relevant Medical Facts Pertaining to this Condition: (Layman's language please)

Dates and Treatment for this Condition:

If patient was hospitalized: Date Admitted: _____ Date Released: _____

Were there complications arising from this illness/surgery? Yes _____ No _____

Is yes, please explain:

Is this an elective procedure or any procedure that could be scheduled without detriment to the member's health, at a time more compatible with the member's work responsibilities? Yes _____ No _____

Identify the job functions the employee is not able to perform:

Date Employee can return to work: _____

Will employee need additional follow-up treatments, if yes, please describe: _____

Date

Signature of Physician

Physician's telephone number

Please print physician's name