|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Sick Leave Bank Request  Application for SLB Grant | | | Requests to Draw from SLB MUST BE RECEIVED WITHIN 30 CALENDAR DAYS from the First Day of Bank Usage. Please PRINT or TYPE all Information | | | | | | |
|  | Return ORIGINAL FORM to:  Mecca Woods  Payroll Dept. Central Office  102 S Hickory Ave, Bel Air, MD 21014 | | | Employee ID Number | | | | | Hire Date | |
|  | Name:  LAST First Ml | | | | | | | | | Date of Application |
|  | Address: Number and Street City or Town State Zip | | | | | | | | | Home Telephone# |
|  | School Name | | | | Position | | | | | School Telephone# |
|  | All Accumulated Leave (Sick/Personal Business/Annual) Must Be Depleted Before Receiving Bank Days  Number of Duty Days Requested I I  (Not to exceed 30 days per request form) FROM *I I* THROUGH *I I* | | | | | | | | | |
|  | Have you received treatment for any condition of illness in the past 90 days? YES NO If yes, please explain | | | | | | | | | |
|  | Is this an illness or injury resulting from or related to an incident on the job or other situation covered by Worker's Compensation?  Yes No Not Applicable | | | | | | Have you filed for Worker's Compensation?  Yes No | | | |
|  | Type of Grant? Initial Grant Request 2nd Grant Request 3rd Grant Request | | | | | | | | | |
|  | I hereby authorize the Harford County Board of Education to release information from my personnel file regarding my medical history, doctor's records, and *I* or letters, and use of sick leave to the HCESC Sick Leave Bank Approval Committee.  *Employee's*  *Signature Date:* | | | | | | | | | |
|  | *To Be Completed By Principal and/or Supervisor* | | | | | | | | | |
|  | First Day of Absence | | Has Employee Returned to Work?  Yes No | | | | | If Yes -Date Returned  *I I* | | |
|  | Comments: | | | | | | | | | |
|  | Signature of Principal and *I* or Supervisor | | | | | | | | Date | |
|  | *HCESC Use Only* | | | | | | | | | |
|  | Leave Depleted?  Yes No | First Unpaid Day  *I I* | | | | | | Portion (Hours) Unpaid of First Unpaid Day | | |
|  | Date Info Confirmed  *I I* | First Day of Absence  *I I* | | | | | | Info Provided by  in Payroll Dept. | | |
|  | *To Be Filled Out By Sick Leave Bank Committee* | | | | | | | | | |
|  | Request Approved I Authorized  Yes No Signature | | | | | | | | Date | |
|  | Circle Duty Days Approved by SLB Approval Committee  Month I 2 3 4 5 6 7 8 9 10 II 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | | | | | | | | | |
|  | Month I 2 3 4 5 6 7 8 9 10 II 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | | | | | | | | | |
|  | Month I 2 3 4 5 6 7 8 9 10 II 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 | | | | | | | | | |
|  | Total Number of Hours Granted | | | | | Total Number of Days Granted | | | | |
|  | Comments | | | | | | | | | |

HCESCSLBRequestandPhySi.c'lanForm *I* ReviSedJuly2008 *I* Page 1 of 2

No Sick Leave Bank days will be Granted without receipt of this completed, original form.

Return ORIGINAL FORM to: Mecca Woods Payroll Dept. Sick Leave Bank

102 S. Hickory Ave, Bel Air, Maryland 21014 Physician's Statement

To be completed by the patient and returned by the Physician or the Patient. The *Sick Leave Bank Grant Application (page 1)* should accompany this form. Patient's Name and Address (Street, City, State, and Zip):

Authorization to release information:

I hereby authorize the designated physician to release to the Sick Leave Bank Approval Committee of the Harford County Educational Services

Council pertinent information from my medical file gathered in the course of my examination or treatment.

Signature of Patient: Date:

Name of Physician Physician's Telephone

Address of Physician (Street, City, State, Zip)

TO BE COMPLETED BY PHYSICIAN DESIGNATED ABOVE BY APPLICANT

*This patient is requesting a grant of sick days provided through donations to the Sick Leave Bank by fellow employees. Please provide, in terms that will be understood by the screening committee, a complete statement of medical diagnosis clearly confirming the CATASTROPHIC OR INCAPACITATING nature of the patient's condition. Include the treatment plan. If*

*maternity related, list estimated/actual delivery date. Use additional paper if necessary.*

*Please check those that apply:*

This patient's condition is Catastrophic. This patient's condition is a permanent disability.

This patient's condition is Incapacitating.

Patient is under my care and is disabled: If currently disabled, date patient should Date patient was last be able to return to work: seen by doctor:

FROM: *I I* THROUGH: *I I*

Physician's Name (Please Print) Physician's Telephone

Physician's Signature Date

Address (Street) (City) (State) (Zip)

HCESC SLB Request and Physician Form *I* Revised July 2008 *I* Page 2 of 2