Lamesa Independent School District

Every Student Every Day

Sick Leave Bank Request Form

Employee Information

Employee Name: _____ # of years in LISD: _____

Address: _____ Phone Number: _____

Position: _____ Campus/Dept: _____

I certify that I have donated one or more days of my available local sick leave to the Sick Leave Bank and have been a member since (date) _____.

Sick Leave Bank Criteria

ALL FIVE CRITERIA MUST BE IN PLACE IN REQUESTING DAYS FROM THE SICK LEAVE BANK:

- I am a member of the Sick Leave Bank.
- I have exhausted all my available state leave, local leave, vacation days accrued and extended leave.
- I am experiencing a catastrophic illness/injury, and I am unable to return to work due to this medical condition.
- I am attaching the Physician's Statement form as verification of my medical condition.
- I verify that I am not receiving monies from any other insurance benefit or workers' compensation act.

Request Information

Number of Day Requested _____

Sick Leave Days should begin: (Month/Date/Year) _____

# of SLB days used since Sept 1 of current year _____

Description of Illness or injury:

_____

_____

_____

Signature: _____ Relationship: _____ Date: _____

Committee Decision

_____ Approved SLB days for_____ Days

_____ Not Approved

_____ Other

Signature: _____ Date: _____

(Committee Chairperson)

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Physician's Statement

Physician's Information

Physician's Name: _____ Clinic/Hospital: _____

Address: _____ Phone Number: _____

Patient's Name: _____

Treatment

Nature of Illness or injury:

_____

_____

_____

Dates of Treatment: _____

Hospitalization, if any, and name and address of hospital:

Date Admitted: _____ Date Discharged: _____

Name of Hospital: _____

Address: _____ Phone Number: _____

Is the patient still under your care? ____ yes ____ no

Date patient can return to work: _____

Physician's Signature: _____ Date: _____