

Sick Leave Bank Utilization Request Form

Name: _____ Employee ID No.: _____

Address: _____

Home Phone: _____ School: _____

Number of Years in Cherry Creek School District: _____

Number of leave days requested: _____

1. Coincident with a request to the Sick Leave Bank Board, a member must make application to the District's Long Term Disability carrier for disability benefits.
2. This form may be submitted prior to the actual use of requested days, but must be submitted within ninety (90) calendar days after the Sick Leave Bank member returns to work for the Sick Leave Bank Board to consider the request.
3. For your own protection, please read Policy 4151 for Teachers, Policy 4873 for Mental Health employees and Policy 4751 for Nurses along with Administrative Procedure 4151.2.
4. Before the Sick Leave Bank Board will consider your request, you must submit:
 - a. A licensed physician's verification that the illness or disability is total and renders the employee incapable of working.
 - b. Actual or expected date of return to work.
 - c. A completed application form for long-term disability (LTD).
 - d. A medical leave of absence request.

IMPORTANT:

- I understand that by signing below, I am waiving any privacy protection afforded me by Colorado law and/or District policy only as to the following: 1) SLBB members who review the documents as part of their SLBB membership duties and responsibilities; and 2) the documents insofar as they are used for SLBB purposes.
- The disclosure of this information is voluntary, and I have the right not to provide specifics of my medical condition to the Sick Leave Bank Board.
- I can refuse to sign this authorization. If I do not sign this authorization and do not provide the required documents, the Sick Leave Bank Board may not be able to approve my application for sick leave from the bank.

TEACHING PERSONNEL

Policy: 4151.4

- I may inspect or copy the information to be used or disclosed.

Employee Name (please print): _____

Employee Signature: _____

Date: _____

Physician's statement of the nature of the illness/disability: _____

I certify that this illness/disability is total and renders the member incapable of working:

NOTE: Your patient has exhausted all available personal sick leave and is now requesting a Leave With Pay from the Sick Leave Bank.

Actual or Expected Date of return to work: _____

Physician's Signature: _____

Date: _____

Phone: _____

Revised: September 24, 2014

Adopted: June 15, 2015

Effective: July 1, 2014