CLAY COUNTY SCHOOLS
SICK LEAVE BANK WITHDRAWAL APPLICATION

I – APPLICANT

Applicant: _____ Work Location: _____
Address: _____ Home Phone No: _____
_____ Social Security No: _____
Date Submitted: _____ Last Day of Work: _____
Enrolled S.L.B. Yes ___ No ___ Date Leave Began: _____
All Sick Leave has been used: Yes ___ No ___ Sick Leave Expired on: _____
Illness or Injury in Line of Duty Leave: Yes ___ No ___
Drawing Disability Payments: Yes ___ No ___
Drawing Worker's Compensation: Yes ___ No ___
Estimated Additional Sick Days Needed: _____
Nature of Illness or Injury: _____
Attending Physician: _____
Comments or Supporting Information: _____
_____
Date Due to Return to Work: _____

I certify that the above information is correct and true. I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim, to the Clay County Sick Leave Bank Committee.

(A Photostat of this authorization shall be as valid as the original) _____
Applicant's Signature

Forward all copies to the Business Affairs Division with Physician statement attached.

II– CLAY COUNTY SICK LEAVE BANK COMMITTEE DISPOSITION

Application Received on: _____ Action Taken On: _____
Application: Approved: _____ Denied: _____
Credit: _____ with _____ day(s) from the Sick Leave Bank.
Effective Date: _____ Comments: _____
_____
Authorized Signatures (*3 Required*):
1. _____ 2. _____ 3. _____

CLAY COUNTY SCHOOL BOARD

PHYSICIAN FORM

APPLICANT: Have this form completed by attending physician and return with the Sick Leave Bank Application. FORM MUST BE COMPLETELY FILLED OUT before application will be considered.

PHYSICIAN: Complete this form and return it to the patient. If you have questions, please contact the Sick Leave Bank Committee, Clay County Education Association, c/o Shannon Beavers, Chair, Fleming Island Elementary, 4425 Lakeshore Dr Fleming Island, FL 32003, Fleming Island, FL 32003.
Email: Shannon.Beavers@myoneclay.net

APPLICANT INFORMATION

Name: _____

Address: _____

Phone No: _____

PHYSICIAN INFORMATION

Name: _____

Address: _____

Phone No: _____

M.D. _____ D.O. _____

Specialty _____

Diagnosis: _____

Is patient now physically disabled? _____

Prescribed treatment: _____

_____

Was patient previously treated for this problem? Yes _____ No _____

If yes, when? _____

Estimate date patient will be physically able to return to full time work: _____

Anticipated restrictions upon return to work: _____

_____

For maternity leave, please state estimated due date: _____

Please note any other pertinent information that may be helpful to the Sick Leave Bank Committee in making a decision about granting days to this patient: _____

_____

_____

_____

Signature of Physician