CENTER INDEPENDENT SCHOOL DISTRICT
SICK LEAVE GRANT APPLICATION

Employee Name: _____ **ID #:** _____

Campus/Department: _____

Position: _____

I would like to request _____ days from the Center ISD Sick Leave bank for the following reason:

_____

_____

_____

Request Beginning Date: _____ **Request Ending Date:** _____

I understand that I must be a contributing member of the Center ISD Sick Leave Bank at the time of this request for it to be considered by the committee. I also authorize the Sick Leave Bank committee to obtain further information pertaining to this request from my attending physician.

Employee Signature: _____ **Date:** _____

Physicians Statement:

Patient's Name: _____

Nature of sickness/injury: _____

_____

_____

Date(s) of Treatment: _____

Date(s) hospitalized, if any: _____

Hospital Name: _____

Was surgery scheduled? ☐ Yes ☐ No

Were there complications arising form this illeness/surgery? ☐ Yes ☐ No

If yes, please explain: _____

_____

How long will/was the patient be unable to perform their regular job duties?

_____

Date patient can return to work: _____

Physicians Signature: _____ **Phone Number** _____

Printed Name: _____ **Date:**

Office Use Only:

Date Received: _____ ***Request #:*** _____

Committee Response: ☐ ***Approved*** ☐ ***Denied***

Number of days granted from bank: _____

Committee Signature: _____ ***Date:*** _____

** All completed requests, including medical certification, should be submitted to Holly Mikesh**