BALTIMORE CITY PUBLIC SCHOOL SYSTEM PSASA Union	REQUEST FOR USE OF SICK LEAVE BANK	REVISED 7/17	P - 25 - A
		SICK LEAVE BANK	REQUEST #

PART I

INSTRUCTIONS TO PARTICIPATING SICK BANK MEMBER (Educational Staff)

1) **Complete and sign Part I (type or print legibly).**
2) **Forward to Attending Physician to complete Part II.**
3) **Submit both copies of completed original form along with a copy of your most recent payroll check stub, to the Sick Leave Bank Committee,** PO Box 194 3608 Offutt Road Randallstown, MD 21133
4) **We are not responsible for lateness or illegible forms. Applications received after the committee has met will be reviewed at the next scheduled Sick Bank meeting.**
5) **Faxed forms are not acceptable. (This includes any / all electronic files, emails, jpegs, text, and etc.)**

Applicant Name: _____

Applicant Address: _____ Zip: _____
City State

Email Address: _____

Phone: _____ Employee ID#: _____

Yrs. of Active Service: _____ Payroll Location: _____

Location Previous Two (2) Years: _____

Previous Illnesses in Excess of Five (5) days:
(additional sheet may be attached if needed. If none, please indicate.)

Dates	Nature of Illness
_____	_____

I request to borrow _____ days from the Sick Leave Bank.

Falsification and/or distortion of information on the application will result in automatic denial of Sick Bank grants.

Signature: _____ Date: _____

PART II

THIS SECTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN ONLY.

1) Please type or print legibly. Illegible applications may not be approved.
2) Treatment plan MUST be included with each illness.
3) Maternity disability period not to exceed ten weeks, includes time before and/or after the delivery of the child.
4) Attach additional sheets if necessary.

Nature of Illness and prognosis _____

_____

First day Employee is unable to work _____ Return to work date _____

Physician's Name: _____ Phone: _____

Physician's Address: _____ Zip: _____
City State

Signature: _____ Date: _____

PART III

SICK LEAVE BANK COMMITTEE ONLY

Days requested_____ Number of Days Granted_____

First day employee is unable to work _____

Return to work date _____

APPROVED _____

DENIED _____

Authorized Signature: _____ Date: _____