

RHEA COUNTY SCHOOLS  
FORM FOR ENROLLING  
IN THE SICK LEAVE BANK

TO: Finance Department, Superintendent's Office

I, \_\_\_\_\_ SSN \_\_\_\_\_  
Last name First name MI

***authorize the transfer of one (1) day from my sick leave to the Employee Sick Leave Bank. This authorization will also serve for future transfer as requested by the Sick Leave Bank Committee.***

I understand that only certified employees are eligible for the initial enrollment. I further understand and agree to the provisions of the employee Sick Leave Bank and relieve the Rhea County School System and the Sick Leave Committee members of any liability resulting from action by the Employee Sick Leave Bank committee Members.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee's Position and Location \_\_\_\_\_

RHEA COUNTY SCHOOLS  
SICK LEAVE BANK REQUEST FORM  
DATE \_\_\_\_\_

**SECTION A – TO BE COMPLETED BY EMPLOYEE (PRINT OR TYPE):**

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

School \_\_\_\_\_ Position \_\_\_\_\_

Home Address \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

Is this injury/illness work related? \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of Last Day Worked \_\_\_\_\_ Number of Days Requested \_\_\_\_\_

Accumulated to Date: Vacation Days \_\_\_\_\_ Sick Leave Days \_\_\_\_\_

Describe the nature of your catastrophic illness: \_\_\_\_\_

1. The Sick Leave Bank is available to a member with a catastrophic illness or disability causing absence from work for an extended period of time.
2. The member must have been absent, due to catastrophic illness or disability, at least five (5) working days following the exhaustion of all available paid leave.
3. The maximum number of days any member may apply for is twenty (20) consecutive days. The maximum number of days a participant may receive in a fiscal year (July 1 – June 30) is sixty (60). The maximum number of days a participant may receive as a result of any one illness or accident is ninety (90).
4. All leave granted but not used will be returned to the Sick Leave Bank.

5. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

6. *I authorize my physicians to release information relating to my catastrophic illness or disability to the Rhea County School System's Sick Leave Bank:*

\_\_\_\_\_  
Signature of Employee or Designee

**SECTION B – TO BE COMPLETED BY SICK LEAVE BANK COMMITTEE:**

Employee's Name \_\_\_\_\_

Date Request Received \_\_\_\_\_ Physician's Statement Attached \_\_\_ Yes \_\_\_ No

Member's Accumulated Leave Ends/Ended \_\_\_\_\_

First Day of Work Missed For This Illness \_\_\_\_\_

Request Granted \_\_\_\_\_ Number of Days Granted From Sick Leave Bank \_\_\_\_\_

Request Denied \_\_\_\_\_ Reason Denied \_\_\_\_\_

\_\_\_\_\_  
Signature of Sick Leave Bank Committee Member

RHEA COUNTY SCHOOLS  
PHYSICIAN'S FORM FOR VERIFYING  
CATASTROPHIC ILLNESS OR DISABILITY OF EMPLOYEE

Name \_\_\_\_\_ SSN \_\_\_\_\_  
Last First MI

School \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address

\_\_\_\_\_ City State Zip Code

PHYSICIAN'S REPORT OF CATASTROPHIC ILLNESS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Disability Begins \_\_\_\_\_ Estimated Date Disability Ends \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_  
Street Address

\_\_\_\_\_ City State Zip Code

*I certify that the above named employee is under my care and will be unable to perform normal duties during this period. Adjustments in these dates may be necessary at a later date.*

\_\_\_\_\_  
Physician's Signature Date \_\_\_\_\_