RETURN THIS COMPLETED FORM BY ___/___/___ TOTAL DAYS USED ______ AS 0F ___/___/___

UNIFIED SICK LEAVE BANK APPLICATION *Claim/Case #*

AFSCME CASE ESPBC OPE NON-REPRESENTED (NR)

Complete this form 10 business days prior to using all of your accumulated sick and urgent personal business leave. Send the completed form to your Bargaining Unit's Sick Leave Bank Committee (AFSCME,ESPBC) or Risk Management (CASE,OPE,NR). FAILURE TO FULLY COMPLETE FORM MAY RESULT IN DENIAL OF THE APPLICATION.

Employee Information – PLEASE TYPE OR PRINT

Name__________________________________ SSN (last 4 digits) __________ Date of Birth ___________Date of Application _____________

Address___________________________________ City_____________________ State _________ Zip ___________ Phone ________________

Work Location ___________________________ Position ________________________ BCPS Service Years_______

Employment Status ____10 months ____12 months ____Full time ____Part time (choose one) .9 .8 .7 .6 .5 .4 .3 .2

Have you drawn from a BCPS sick leave bank? ____Yes ____No

Is this illness/injury work related? ____Yes ____No If Yes, have you filed a workers compensation claim?________________________ (estimated date)

Employee Authorization to Release Medical/Health Care Provider Information

I hereby authorize the undersigned physician/health care provider to release any information concerning my physical condition, examination, and/or treatment as it relates to this application to my bargaining unit's sick leave bank committee and to the BCPS Office of Risk Management.

Signature of Member/Patient ___________________________________ Date______________________

IF applicable: Name *and* signature of individual completing form on member/patient's behalf _______________________________________

Relationship to member/patient ________________________________

Medical/Health Care Provider Information
For Physician's/Health Care Provider's Use Only : NOT to be Completed by the Employee

Patient is under my care and unable to work from (start date) _____________to (end date) ____________ Anticipated RTW date _______________

Specific diagnosis and comments (what **DISABLING ILLNESS/INJURY** is preventing the employee's return to work?): ____________________

____ ICD/DSM Code ______________________

Plan of treatment:____

Prognosis: ____

Upon returning to work, do you anticipate the employee will need work restrictions or accommodations? ______ Yes ______ No

Maternity Cases: Expected Date of Birth ________________________ **NOTE: Claimant MUST notify her bargaining unit's Sick Leave Bank's Committee and the Department of Human Resources of the actual date of birth.**

____

Physician's/Health Care Provider's Name (please type or print) Address Phone Date

____ _________________ __________________________________

Physician's/Health Care Provider's Signature License # Board Certification/Specialty

Bargaining Unit Sick Leave Bank Committee/Risk Management

Approved: _____ Yes _____ No Number of Days: __________ Beginning Date: ____________ Ending Date: ________________

If denied, attach statement of reason(s) First day out of work: ____________________

Date accumulated sick leave and urgent personal business days will be exhausted: _______________________

Name of Bargaining Unit SLB Chairperson: _________________________________ Signature:_________________________ Date: ___________

Office of Risk Management

Approved: _____ Yes _____ No Comments: ____________________________ IME Requested: _________________ Completed: ___________

c: Bargaining Unit USLB, employee, Risk Management Signature of Manager __________________________________ Date: _____________

DATE FORM SENT TO EMPLOYEE:_____/_____/_____ DATE FORM RECEIVED FROM EMPLOYEE: _____/_____/_____