Birdville Independent School District

Request for Sick Bank Leave Days

Employee to complete

Name: _____ Employee ID #: _____

Job Title: _____ Campus/Dept: _____

Email: _____ Day Phone #: _____

I am requesting Sick Leave Bank days to care for:

My Own Injury/Illness

An Immediate Family Member's Injury/Illness

If for an immediate family member, please list your relationship: _____

Number of days requesting from the Bank (max 30 for self, 20 for family) _____

Sick Bank days should begin _____

Last day of accruals (State, Local, Vacation, Comp Time) _____

First date of treatment for this absence _____

Do you anticipate any additional days to be needed for follow-up examinations or treatments? Yes _____ No _____

Do you have an open Workers Comp claim for the above request? Yes _____ No _____

The above requested days are needed for the reason of catastrophic illness as described in the attached physician's statement, for myself or that of an immediate family member. I hereby authorize the Sick Leave Bank Governing Board to obtain further information pertaining to this request from my attending physician. Yes _____ No _____

Do you authorize the release of your FML paperwork in lieu of the Sick Bank Physician's Statement? Yes _____ No _____

Please return completed form to the Benefits Office.

Fax #: 817.547.5580 **Email: susan.dippolito@birdvilleschools.net**

_____ _____

Signature Date

Revised January 2023

Birdville Independent School District

Employee Sick Leave Bank

Attending Physician's Statement

TO THE ATTENDING PHYSICIAN: Your patient is requesting extended sick leave benefits from the Birdville Independent School District that will afford the patient full payment for up to 30 days of sick leave in the event they are not able to work due to a catastrophic illness or injury, or need to care for an immediate family member with a catastrophic illness or injury. Prior to approving any payment for days lost, a doctor's statement is required concerning the patient's illness. **Please fax the completed information below to 817-547-5580.**

Employee's Name:

_____

Patient's Name: _____ Relation to Birdville ISD employee _____

Relevant Medical Facts Pertaining to this Condition: (Layman's language please)

_____

_____

_____

Dates and Treatment for this Condition:

_____

_____

_____

If patient was hospitalized: Date Admitted: _____ Date Released: _____

If there were complications arising from this illness/injury/surgery, please explain:

_____

_____

_____

Is this an elective procedure or any procedure that could be scheduled without detriment to the member's health, at a time more compatible with the member's work responsibilities? Yes _____ No _____

Identify the job functions the employee is not able to perform, or the functions the employee will be providing to the family member:

_____

_____

_____

Expected date employee can return to work: _____

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If additional follow-up appointments/treatment will be needed, please describe:

_____

_____

_____

_____ _____

Date Physician's Signature

_____ _____

Physician's telephone number Physician's Printed Name