SICK LEAVE BANK CONTRACT

_____ has been ***approved*** for use of _____ days from the Sick Leave Bank. Use of the Sick Leave Bank is contingent upon the following conditions:

1. Personal presentation of physicians' certification of continuing illness on the date, time, and place to be determined by the Committee. (An exception to the above will be accommodated in those instances where the teacher is physically incapacitated, in which case said teacher requesting use of the Sick Leave Bank shall be represented by a person or persons of their choice.)
2. Written statement of anticipated duration of need to the Sick Leave Bank.
3. That said person is not employed during use of Sick Leave Bank.

_____ _____

Date Applicant's Signature *[or authorized representative]*

_____ has been ***denied*** use of ____ days from the Sick Leave Bank for the following reasons:

_____

_____

_____

_____

You have the right to appeal this decision per Section 12. Please follow these instructions if you wish to appeal.

Sick Leave Bank Committee Members:

_____ _____

SEA Trustee SEA Trustee

_____

Administration Trustee

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I do hereby authorize and direct any licensed practitioner to provide the Sick Leave Bank Trustees any medical information acquired for the purpose of diagnosis and treatment while attending me in a professional capacity.

_____ _____

Patient's Name Patient's Signature

_____ _____

Social Security Number Date Release Signed

Trustee Assigned_____ *10/98*

APPLICATION FORM - SICK LEAVE BANK

Applicant's Name:_____ Date:_____

Address:_____ Phone:_____

School:_____ Age:_____ No. of Years in District:_____

Name or description of present illness: _____

_____

Total number of accumulated sick days prior to present illness: _____

Date first absent from school due to present illness: _____

Have you received benefits from the Sick Bank previously? _____ When?_____

Date you wish to begin drawing from the Sick Leave Bank: _____

Physician's name: _____

Address: _____

_____

(Attach two (2) physician's statements ***directly to this form***. You will need to submit a physician's statement at the ***first of every month that you are using the Sick Leave Bank***.)

Approximate date of return to school (if known): _____

Have you worked at all, in any capacity, since you became disabled? ___Yes ___No

Do you have any other disability insurance coverage available to you? ___Yes ___No

Are you or will you be employed while on Sick Bank? ___Yes ___No

Are you or will you be participating in a business venture while on Sick Bank? ___Yes ___No

FAILURE TO REPORT OTHER SOURCES OF INCOME WILL RESULT IN TERMINATION OF BENEFITS.

I attest that the above statements are true to the best of my knowledge.

_____

Applicant's Signature *[or authorized representative]*

10/98

SPRINGFIELD PUBLIC SCHOOLS - SPRINGFIELD EDUCATION ASSOCIATION

PHYSICIAN'S REPORT OF DISABILITY

(Definition of disability is a generic definition, not a legal definition.)
(please print or type)

1. Name of claimant _____
2. Date claimant disabled _____
3. Dates of treatment _____
4. Was claimant able to continue to work after the disability*?____ How long? _____
5. Was claimant treated by another physician?____ Name _____
   Address _____
6. Was claimant hospitalized?____ Name of hospital _____
   From _____ To _____
7. What is the precise nature and extent of disability _____
   _____
   _____
8. Has claimant any chronic or constitutional disease or physical defect or deformity? _____
   What? _____
9. What complications have arisen? _____
10. Have there been any laboratory tests made?____ Results? _____

11a. Was surgery performed?____ Briefly describe:_____ When? _____

11b. Is surgery elective? ____ If yes, is surgery necessary now, or could it be safely performed during summer vacation months?

12. Is claimant now able to resume any portion of teaching duties?_____ Since when? _____
13. What, in your opinion, is the probable duration of this disability? _____
14. What is the approximate date when member may be able to resume assigned teaching duties? _____
    In your judgment, could claimant return to teaching duties on a part-time basis?_____
15. In your judgment, is the claimant incapacitated from duties as a teacher permanently or temporarily?
    _____

I, a practicing physician, registered under the laws of the State of _____, my registry number being _____, certify my answers to the foregoing questions are complete and true to the best of my knowledge, information, and belief.

Dated_____ Signed _____

Phone Number _____ Street Address _____

City, State, Zip _____

10/98

SPRINGFIELD PUBLIC SCHOOLS - SPRINGFIELD EDUCATION ASSOCIATION

PHYSICIAN'S REPORT OF DISABILITY

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   What? _____
9. What complications have arisen? _____
10. Have there been any laboratory tests made?____ Results? _____

11a. Was surgery performed?____ Briefly describe:_____ When? _____

11b. Is surgery elective? ____ If yes, is surgery necessary now, or could it be safely performed during summer vacation months?

12. Is claimant now able to resume any portion of teaching duties?_____ Since when? _____
13. What, in your opinion, is the probable duration of this disability? _____
14. What is the approximate date when member may be able to resume assigned teaching duties? _____
    In your judgment, could claimant return to teaching duties on a part-time basis?_____
15. In your judgment, is the claimant incapacitated from duties as a teacher permanently or temporarily?
    _____

I, a practicing physician, registered under the laws of the State of _____, my registry number being _____, certify my answers to the foregoing questions are complete and true to the best of my knowledge, information, and belief.

Dated_____ Signed _____

Phone Number _____ Street Address _____

City, State, Zip _____

10/98

SPRINGFIELD PUBLIC SCHOOLS - SPRINGFIELD EDUCATION ASSOCIATION

PHYSICIAN'S REPORT OF MATERNITY DISABILITY

(Definition of disability is a generic definition, not a legal definition.)
(please print or type)

1. Name of claimant _____

2. Date on which claimant was disabled to the extent she could on longer perform her duties as a teacher

_____

3. Anticipated date of delivery _____

4. Anticipated date the disability will cease and the claimant is able to again engage in gainful employment _____

I, a practicing physician, registered under the laws of the State of _____, my registry number being _____, certify my answers to the foregoing questions are complete and true to the best of my knowledge, information, and belief.

Dated_____ Signed _____

Phone Number _____ Street Address _____

City, State, Zip _____

Detach & submit Pregnancy Supplemental AFTER the birth of the baby.

PHYSICIAN'S CERTIFICATE - PREGNANCY SUPPLEMENTAL

For: Springfield Education Association - Sick Leave Bank

Re: _____

Date:_____

1. Indicate the date on which claimant was disabled to the extent she could no longer perform her duties as a teacher_____

2. Indicate **EXACT** date of delivery _____

3. Was the delivery by Cesarean Section? _____

Signed _____

Street Address _____

City, State, Zip _____

FAILURE TO RETURN THIS FORM WITHIN 14 CALENDAR DAYS OF DELIVERY WILL RESULT IN TERMINATION OF BENEFITS UNTIL RECEIPT BY A TRUSTEE.

10/98

STATEMENT OF UNDERSTANDING

Applicant: _____ Date: _____

Representative: _____

Trustee: _____

I understand that:

___ I have a lifetime Sick Bank total of _____ days available to me and that the days I receive will be subtracted from that total.

___ I am responsible for checking with payroll regarding the official date of return from Sick Leave.

___ I have 6 calendar weeks of maternity leave from the date of the birth of my baby (8 weeks for Cesarean).

___ I have 14 days to report the birth of my baby to my trustee or my benefits will be suspended.

___ I must report my return to work to my Trustee and to the Department of Human Services.

___ If I am on Sick Leave when school starts and I have been approved for Sick Bank, the days I receive when I return to work will be returned to the Sick Bank.

___ I can apply for TRS disability for my chronic illness.

___ I must submit a monthly letter from my physician of my continuing inability to work.

___ My benefits will be suspended if I fail to comply with the Sick Bank Bylaws.

___ I have the right to appeal the decision of the Sick Bank Trustees to the SEA Executive Committee..