

Hereford Independent School District
Sick Leave Bank Request Form

Employee Request # _____

Attach Hereford I.S.D. Sick Leave Bank Physician's Statement Form and an FMLA Form - Forward All Copies to Business Office. **To avoid a delay in the decision from the Bank, please provide all necessary information.**

SCHOOL _____ ASSIGNMENT _____
NAME _____
First Middle Last
ADDRESS _____
Street City State Zip
SOCIAL SECURITY # _____ TELEPHONE # _____

Number of Days Requested from Bank:
Plan A: _____ Plan B: _____ Plan C: _____

Nature of Disability: _____

I hereby authorize the Hereford I.S.D. to release information from my personnel file regarding my medical history, doctor's records and/or letter, and use of sick leave in order that the Sick Leave Bank Committee can determine if I am eligible for leave days from the Sick Leave Bank. **I understand that the Sick Leave Policy and the Committee decision is final. I also affirm that at the time I joined the Sick Leave Bank, I was unaware of the condition for which I am requesting days.**

Employee's Signature (Family Member/Agent) Date

Verification of Absence _____
Comments _____

Last Day at Work _____

Signature of Immediate Supervisor Date

SICK LEAVE BANK COMMITTEE (OFFICE USE ONLY)

Request Approved: _____ Yes _____ No

Signature: _____ Date: _____

Comments: _____

Number of Days Approved: _____ Unanimous or _____ For _____ Against

**Hereford Independent School District
Physician's Statement**

THE SECTION BELOW TO BE COMPLETED BY PATIENT/EMPLOYEE

Employee Information:			
Name _____			
First	Middle	Last	
Address _____			
Street	City	State	Zip
Hereford I.S.D. Job Description (please \checkmark appropriately)			
<input type="checkbox"/> Administrator	<input type="checkbox"/> Teacher	<input type="checkbox"/> Clerical	<input type="checkbox"/> Teacher's Aide
<input type="checkbox"/> Maintenance	<input type="checkbox"/> Food Service	<input type="checkbox"/> Custodial	<input type="checkbox"/> Transportation
I authorize the release of my medical information to the Hereford I.S.D. Sick Leave Bank Committee.			
_____		_____	
Signature of Hereford I.S.D. Employee		Date	

THE SECTION BELOW TO BE COMPLETED BY PHYSICIAN

The medical diagnosis of the condition(s) causing illness or injury is (please be specific and also state the date of surgery if applicable): _____	
Prognosis (please \checkmark one of the following choices):	
<input type="checkbox"/> 1. Released to work with no restrictions.	Date: _____
<input type="checkbox"/> 2. Released to work with the following restrictions:	Date: _____
<input type="checkbox"/> 3. Not released to work; expected release date is:	Date: _____
_____	_____
Physician's Name (Please Print)	Physician's Signature (Please No Rubber Stamp)
_____	_____
Mailing Address	Telephone Number
_____	_____
City State Zip	Date
_____	_____

Note to Physician: Please return this completed Physician's Statement Form to patient for submission with Sick Leave Bank Request form.

Hereford I.S.D. employee or family member should return the Physician's Statement and the Sick Leave Bank Request Form to the Hereford I.S.D. Business Office for processing.

***In the event of a death, an obituary or death certificate can replace the physician statement.**