

STATEMENT OF CLAIMANT FOR USE OF SICK LEAVE BANK

DOCTOR'S WRITTEN STATEMENT MUST ACCOMPANY THIS APPLICATION

Applications should be sent to: Sick Leave Bank Committee
Attn: Human Resources
School District No. 193
470 North 3rd East P.O. Box 1390
Mountain Home, Idaho 83647

NAME: _____ TELEPHONE _____

ADDRESS: _____

- 1. Did you stop all work? Month _____ Day _____ Year _____
On what date did you return to work? Month _____ Day _____ Year _____

2. Nature of illness or injury:

- Have you used all your sick leave? Yes _____ No _____
- Have you used all your personal leave? Yes _____ No _____

3. Name and addresses of all doctors consulted:

- 4. Has there been an illness or injury requiring hospitalization or prolonged stay at home during previous years employed by School District No. 193 for which you requested days from the Bank? Yes No

If yes, please explain: _____

I certify the information stated above are true facts relevant to the illness or injury cited in this application, and hereby authorize any hospital, physician, or other provider of medical care, past, present, or future to furnish the Sick Leave Bank Committee with any information from medical records related to the medical history, diagnosis, or treatment of any condition, illness, or injury of the person named on this application.

I hereby authorize the Sick Leave Bank Committee to obtain from School District No. 193 any pertinent information relative to Personal and/or Sick Leave from my payroll and /or personnel records.

APPLICANT'S SIGNATURE: _____

DATE: _____