CLASSIFIED EMPLOYEES' ASSOCIATION

SICK LEAVE BANK

WITHDRAWAL REQUEST FORM
(For employee's illness or Injury only)

NAME:__________________________ **DATE:**__________________________

MAILING ADDRESS:______________________
(Street or P.O. Box)

POSITION TITLE:__________________________

____
(City, State, Zip)

LOCATION:_____________________

PHONE NUMBER:_________________

Are you a member of the Sick Leave Bank? _____ Yes _____ No

Did this injury or illness originate as a Worker's Comp Claim? _____ Yes _____ No
If yes, date of original Worker's Comp Claim: _____________________

Outline your need for the request:____

____

____

Period of Absence:____

Number of days requested from the bank:__________________

Request for Paragraph 2.B (40 hrs) Exception:_________________

Have you previously applied for a withdrawal from the bank? _____ Yes _____ No

- FOR THE PURPOSE OF ADMINISTERING THE SICK LEAVE BANK, "UNUSUAL CIRCUMSTANCES" SHALL BE DEFINED AS ANY SERIOUS PHYSICAL OR EMOTIONAL DEBILITATING ILLNESS WHICH RESULTS IN A PROLONGED ABSENCE.
- ALL REQUESTS FOR WITHDRAWAL FROM THE SICK LEAVE BANK MUST BE ACCOMPANIED BY A CERTIFICATION OF HEALTH CARE PROVIDER FORM COMPLETED BY A PHYSICIAN.
- ALL LEAVE (SICK LEAVE, ANNUAL LEAVE, FLOATING HOLIDAYS) ACCRUED BY THE EMPLOYEE MUST BE EXHAUSTED EXCEPT BY COMMITTEE APPROVAL FOR LONG-TERM CATASTOPIC ILLNESS.
- PERIOD OF ABSENCE MUST BE A MINIMUM OF FIVE (5) CONSECUTIVE WORKING DAYS.
- MAXIMUM AMOUNT FOR WITHDRAWAL IS 20 DAYS.

____
Signature of Applicant

CEA SICK LEAVE BANK / WITHDRAWAL REQUEST FORM

CERTIFICATION OF HEALTH CARE PROVIDER

Health Care Provider: Please provide as much information as possible for the Sick Leave Bank Committee to determine the applicant's need to be released from work due to illness or unusual circumstances. (For the purpose of administering the Sick Leave Bank, "Unusual Circumstances" shall be defined as any serious physical or emotional debilitating illness which results in a prolonged absence).

Brief description of illness or unusual circumstance:______________________________

____

____

____

____

I recommend that ____, an employee of the
(patient's name)

Matanuska-Susitna Borough School District, be released from work from ___________
(date)

to __________________ because of the illness or circumstance described above.
(date)

____________________________________ ____________________________
Health Care Provider's Name **(Please print)** Office Telephone Number

____________________________________ ____________________________
Health Care Provider's Signature Date