

CLASSIFIED EMPLOYEES' ASSOCIATION

REQUEST FOR SPECIAL COLLECTION OF SICK LEAVE FORM
(For employee's or employee's family member illness or Injury)

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

Family member requiring your absence from work:
 Child Spouse Parent

Outline your need for the request: _____

Period of Absence: _____

Number of days requested: _____

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 REQUEST FOR SPECIAL COLLECTION OF SICK LEAVE, "UNUSUAL CIRCUMSTANCES" SHALL BE DEFINED AS ANY SERIOUS PHYSICALLY OR EMOTIONALLY DEBILITATING ILLNESS WHICH RESULTS IN A PROLONGED ABSENCE.
- ALL REQUESTS FOR SPECIAL COLLECTION OF SICK LEAVE 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, CATASTROPIC ILLNESS.
- PERIOD OF ABSENCE MUST BE A MINIMUM OF FIVE (5) CONSECUTIVE WORKING DAYS.
- MAXIMUM AMOUNT FOR SPECIAL COLLECTION TO CARE FOR FAMILY MEMBER IS 24 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