

Name: Please print or type – Complete and return to the FCTA Office

Last	First	MI	Employee ID	Application Date

Address:

Street and Number	City and State	Zip	Home Phone

School/Dept.	Are you employed somewhere in addition to FCPS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employment Status	10-month <input type="checkbox"/>	11-month <input type="checkbox"/>	12-month <input type="checkbox"/>	Full-Time <input type="checkbox"/>	Part-Time Hrs. per day <input type="checkbox"/>
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Personal Sick Leave Expires:	Number of Days Requested:	Previous Bank Usage	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Authorization to Release Information: I hereby authorize the undersigned physicians to release any information acquired in the course of my treatment or examination to the FCTA Sick Bank Committee.

Signature of Member/Patient

For Treating Physician Use Only		
Please provide a complete statement of the medical diagnosis confirming the catastrophic and incapacitating nature of the condition. If it appears likely that this patient will not be able to return to this type of employment please indicate below.		
Type of print legibly.		
Diagnosis: The physician's diagnosis (in layman's terms) must include an explanation of why patient is unable to work.		
Treatment Plan:		
Can this procedure be reasonably deferred until school is not in session? Yes _____ No _____		Expected Return To Work Date:
Patient was under my care and unable to work	From:	Through:
If still disabled, date patient should be able to return to work. If exact date is not known, show a no-sooner-than date:		
Physician's Name (Please type or print)	Telephone:	
Physician's Signature	Date:	
Physician's Address:		

For Committee and Benefits Use Only			
FCTA Sick Leave Bank Committee:			
Request Approved:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chair:	Date:
Number of Days Approved		From:	To:
Comments:			
FCPS Department of Human Resources			
Request Approved:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Signature:	Date:
Comments:			
Sick Leave Depleted:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Signature:	Date:
Date Processed by Benefits Dept.	Signature:		