| Frederick County Teachers Association<br>1 Worman's Mill Court, Suite 16, Frederick, MD 21701 301-662-9077 | Sick Leave Bank Request<br>**CONFIDENTIAL INFORMATION** |
|---|---|

**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.** | | **Employment Status** | 10-month<br>11-month<br>12-month | ☐<br>☐<br>☐ | Part-Time<br>Full-Time | ☐<br>☐ |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Personal Sick Leave Expires:** | | **Number of Days Requested:** | | **Previous Bank Usage** | YES<br>NO | ☐<br>☐ |

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.

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**Signature of Member/Patient**

## For Treating Physician Use Only – TYPE OR PRINT LEGIBLY

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.

In cases of childbirth, the actual delivery date and type of delivery must be noted on this form in order to be processed.

**Diagnosis: The physician's diagnosis (in layman's terms) must include an explanation of why patient is unable to work.**

**Treatment Plan:**

**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<br>(Please type or print) | | Telephone: | |
| Physician's Signature | | Date: | |
| Physician's Address: | | | |

| **For Committee and Payroll Use Only** | | | | | |
|---|---|---|---|---|---|
| **FCTA Sick Leave Bank Committee:** | | | | | |
| Request Approved: | ☐ Yes ☐ No | Chair: | | Date: | |
| Number of Days Approved | | From: | | To: | |
| Comments: | | | | | |
| **FCPS Department of Human Resources** | | | | | |
| Request Approved: | ☐ Yes ☐ No | Signature: | | Date: | |
| Comments: | | | | | |
| | | | | | |
| Sick Leave Depleted: | ☐ Yes ☐ No | Signature: | | Date: | |
| Date Processed by Payroll Dept. | | Signature: | | | |