Prince George's County PGCEA Educators' Association

SICK LEAVE BANK
Grant Request (Claim) Form
*COMPLETED FORMS SENT BY FAX OR EMAIL *

Last:	First:	EIN:
Contact Phone#:	Non-Work Email:	Birth Date:

a. **Have you filed a Workers' Compensation claim for this illness/injury? Yes ☐ No☐ If yes, date of injury: ____/____ /____**

b. **Do you elect to exhaust your personal leave prior to using the Sick Leave Bank (SLB)? Yes ☐ No ☐**

***REQUIRED EVERY GRANT PERIOD.* Check only One:**

☐ I was using the SLB at the end of the **last school year (JUNE)**; I am renewing my grant for the **new school year (AUGUST)**. ***SUPERVISOR SIGNATURE REQUIRED***

☐ I used the SLB in the past and I returned to work. This is a different grant request (10-day waiting period applies) ***SUPERVISOR SIGNATURE REQUIRED***

☐ This is my first request to use the Sick Leave Bank. (The 30-day waiting period applies) ***SUPERVISOR SIGNATURE REQUIRED***

FOR COMPLETION BY SUPERVISOR: I AM AWARE THE BELOW EMPLOYEE IS REQUESTING AN EXTENDED LEAVE BEYOND (10 CONSECUTIVE DAYS). PLEASE NOTE: ALL DECISIONS REGARDING EXTENDED LEAVES WILL BE DETERMINED BY ABSENCE MANAGEMENT.

SUPERVISOR SIGNATURE:_____DATE: ____/____/____

☐ **I am applying for an extension of grant that was approved this school year (during or after AUGUST)**

***REQUIRED EVERY GRANT PERIOD** **AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the indicated physician to release any information acquired in the course of my treatment or examination to the PGCEA Sick Leave Bank Approval Committee. I understand that information contained on this form and any additional information received may be shared with the Benefits Department of the Prince George's County Public Schools. Any days not used for the specific disability indicated on this form will be returned to the Sick Leave Bank.

I also hereby authorize the Board of Education of Prince George's County to release information from my personnel file regarding my medical history, doctors' records, and/or use of sick leave to PGCEA in order that the PGCEA Sick Leave Bank Approval Committee can determine if I am eligible for benefits from the Sick Leave Bank. I understand PGCEA reserves the right to send me for a second medical opinion, if it is deemed necessary, at my expense. I certify that all the information I provided is accurate.

SIGN HERE ***EMPLOYEE'S SIGNATURE:_____DATE: ____/____/____**

***REQUIRED EVERY GRANT PERIOD** **PHYSICIAN'S STATEMENT TO BE COMPLETED BY PHYSICIAN ONLY**

***ALL QUESTIONS MUST BE ANSWERED Please use the attached job requirements to answer the following questions:**

PRINT

☐ **Condition Start DATE:_____/_____/_____**

▪ ***ICD9 CODE IS REQUIRED**

ICD(9-10)/DSM-IV Codes		Diagnosis and Impact on essential functions of the job:

Condition is ☐Mild ☐Moderate ☐Severe ☐Other:_____

- ☐ Surgery DATE (OR) ☐ Hospitalization DATE (if applicable)_____/_____/_____Prognosis: _____
- Specific Plan of Treatment - including ☐surgery, ☐medications, ☐therapies, or ☐counseling:

☐ What is the usual recovery period for this condition?_____days, weeks, months

▪ Based on the attached job requirements, is the employee *able* to perform essential functions of their job with restrictions? NO ☐YES ☐

If NO, ☐ Temporary absence from DATE____/____/____to DATE:____/____/____**a separate release is required for actual date. (Or)**

☐ Never able to perform essential functions of job

If YES, The patient will medically be able to return to work on DATE:_____/_____/_____.

☐Without restrictions

☐With restrictions

☐ Identify the functions the employee are *unable* to perform:

☐Standing or walking with a seated break as needed	☐Lifting with knees (with straight back) not more than 5 lbs. up to 3 times/hr.	☐Squatting up to 4 times/hr.
☐Sitting with a standing break as needed	☐Work less than standard 4-7.5 hours per day	☐ Driving up to 2 hrs./day
Other:		

☐ Specify accommodations to be made:_____

PHYSICIAN'S NAME (PLEASE TYPE OR PRINT):_____ PHONE ( ) _____

ADDRESS:

BOARD CERTIFICATION SPECIALTY _____ PHYSICIAN'S LICENSE# _____ STATE _____

SIGN HERE ***PHYSICIAN SIGNATURE:_____DATE_____/_____/_____**