THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

APPLICATION TO DRAW LEAVE FROM THE SICK LEAVE BANK

Employee ID# _____ Employee Name _____

Facility Name _____ Position Title _____

Mailing Address _____ Contact Phone # _____

Eligible employees are entitled under School Board Policy 6.911 to a maximum of forty (40) days of paid leave for certain individual medical reasons. Submit this request form to the Sick Leave Bank Administrator at least thirty (30) days before the leave is to commence, when practicable. Use of the sick leave bank counts towards FMLA leave used by employees.

For determination of eligibility, please answer each of the following questions. Put a check in the appropriate response column.

YES	NO	
_____	_____	Is this your first claim for this particular condition?
_____	_____	Have you used the Sick Leave Bank before?
_____	_____	Have you exhausted all of your accrued sick leave days?
_____	_____	Have you ever transferred leave time to another employee within the District?
_____	_____	Have you attached to this application a signed *Physician Form* verifying this condition?
_____	_____	Is your claim for cosmetic surgery or elective surgery which could safely be scheduled during a non-work period?
_____	_____	Have you applied for FMLA with Risk & Benefits Management?

The total number of days of Sick Bank Leave that I request is_____. I request one of the following options (check one):

☐ Sick Leave beginning on_____through _____

☐ Reduced work schedule on the following dates: _____

☐ Intermittent leave according to the following schedule: _____

I agree to return to work on_____. If circumstances change such that I will not be able to return to work on that date, I agree to notify my supervisor within two days with updated leave information and will submit an updated Physician Form to the Sick Leave Bank Administrator.

The following physician or physician's office is authorized to make disclosure of the above individual's health information to Osceola District Schools for the purpose of drawing from the Sick Leave Bank. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Osceola District Schools, Sick Leave Bank Administrator. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire within six months of issuance.

Physician_____

Address _____Phone Number _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect a copy of the information disclosed.

Employee's Signature_____Date _____

Original: Human Resources
Copy: Dept./School