WASHOE EDUCATION ASSOCIATION
SICK LEAVE BANK COMMITTEE

SICK LEAVE BANK ASSISTANCE APPLICATION

Please send this form directly to the WEA Sick Leave Bank Committee. DO NOT send the form to WCSD, it will only delay action on your application.

INSTRUCTIONS FOR USE OF SICK LEAVE BANK ASSISTANCE APPLICATION FORM

1. The employee completes the first section of the form and the doctor completes the second section.
2. All forms and documentation must be provided to the Sick Leave Bank Committee prior to the first Monday of each month.
3. Continuing applications for periods over a month need to submit the monthly update form prior to the first Monday of each month.

Employee Name (please print): ______________________ Home phone: ____________

Home Address: ______________________________ Zip: ____________________

School: ______________________________________ School Phone: ______________

Treating Physician: ______________________________ Phone Number: ______________

Description of illness/disability (attach additional pages, if necessary): ____________________

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____

Number of personal sick leave days already used for this illness or disability: ______________

Number of Sick Leave Bank days requested: ______________________________
(maximum of 75 days per illness per school year by the WEA/WCSD Negotiated Agreement)

Anticipated return to work date: ____

Is this illness/disability work-related (Workers' Comp)? ______________________________

______________________________ ______________________________

Employee's Signature Date

WASHOE EDUCATION ASSOCIATION SICK LEAVE BANK APPLICATION

CERTIFICATION OF HEALTH CARE PROVIDER

1. Employee's Name (Please Print): ______________________________

2. Patient's Name (if different from employee): ______________________________

3. Patient's Diagnosis: ______________________________

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4. Does the diagnosis impact the patient's ability to work? Yes No

   a. If yes, please explain: ______________________________

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   ____

5. Patient's Treatment Plan: ______________________________

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6. Anticipated duration of the treatment plan: ______________________________

____

7.
   a. Is the employee unable to perform work of any kind? Yes No

   b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? ☐ Yes No

   c. If yes, list the essential functions the employee is unable to perform: ______________________________

   ____

   ____

d. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? Yes No

8. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

Yes No

a. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ______________________________

b. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: ______________________________

____

______________________________ ______________________________

Name of Health Care Provider (Please Print) Signature of Health Care Provider

______________________________ ______________________________

Type of Practice Date

____

Phone

WASHOE EDUCATION ASSOCIATION SICK LEAVE BANK APPLICATION

MONTHLY UPDATE FOR CONTINUING APPLICATIONS

1. Employee's Name (Please Print): ______________________________

2. Patient's Name (if different from employee): ______________________________

3. Patient's Diagnosis: ______________________________

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4. Is the patient cooperating with the treatment plan: ☐ Yes No

5. Are there any changes to the treatment plan:

   a. If yes, please explain: ______________________________

   ____

   ____

6. Are there any changes to the anticipated return to work date or treatment plan duration?

   Yes No

   a. If yes, please explain: ______________________________

   ____

   ____

______________________________ ______________________________

Name of Health Care Provider (Please Print) Signature of Health Care Provider

______________________________ ______________________________

Type of Practice Date

____

Phone