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 applicant 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. The applicant needs to provide a report of their Sick Leave usage for the current school year with the application form.

Employee Name (please print): _____ Home phone: _____

Home Address: _____ Zip: _____

School: _____ Personal email address: _____

Treating Physician: _____ Phone Number: _____

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

_____

_____

_____

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: _____

_____

_____

_____

4. Does the diagnosis impact the patient's ability to work? ☐ Yes ☐ No
    a. If yes, please explain: _____

    _____

    _____

5. Patient's Treatment Plan: _____

_____

_____

_____

6. Anticipated duration of the treatment plan: _____

_____

7. Is the employee able to perform work of any kind? ☐ Yes ☐ No
    a. If able to perform some work, is the employee able to perform any one or more of the essential functions of the employee's job? ☐ Yes ☐ No
    b. List the essential functions the employee is able to perform: _____

    _____

    _____

c. 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 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? ☐ Yes ☐ No

   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

UPDATE FOR SICK LEAVE BANK APPROVAL EXTENSION

1. Employee's Name (Please Print): _____
2. Patient's Name (if different from employee): _____
3. Patient's Diagnosis: _____

   _____
4. Is the patient cooperating with the treatment plan: ☐ Yes ☐ No
5. Are there any changes to the treatment plan? ☐ Yes ☐ No
   a. If yes, please explain: _____

      _____

      _____
6. What is the anticipated return to work date or treatment plan duration?

   _____

   _____

_____ _____

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

_____ _____

Type of Practice Date

_____

Phone