SICK LEAVE BANK
INSTRUCTION SHEET

Only persons who are members of the Sick Leave Bank may apply. Sick Leave bank awards are based upon medical necessity and eligibility.

Make sure this application is complete. Your health care provider **MUST** include a "diagnosis, treatment plan, and estimated return to work date".

Only original signatures from physicians -- M.D., D.O., D.P.M. -- will be accepted on applications. A licensed nurse practitioner may sign on sick leave bank requests but not on catastrophic leave bank requests. A diagnosis of mental or emotional illness must be accompanied by a psychiatrist's signature.

If this illness or injury is work related, you may be eligible for Workers' Compensation. If eligible, you MAY NOT apply to the Sick Leave Bank.

AEA MEMBERS ONLY

A false statement by the AEA member regarding sick leave is sufficient grounds for cancellation of the contract and recommendation for revocation of the teaching certificate. (Per AEA/ASD negotiated agreement Article #345-J)

Medical procedures which are elective in nature or that can reasonably occur outside the AEA member's normal work schedule are not eligible for Sick Leave Bank awards.

Anchorage School District

Leave Bank Application

Part A:
To Be Completed by Applicant

Check the type of leave you are applying for.

☐ Sick Leave Bank Request
☐ Catastrophic Leave Bank Request

Last Name (Please Print)	First Name	SS#

Mailing Address	Home Phone	Job Title/Work Location

Incomplete information will lead to the denial of a sick leave bank award.

*** Have you been off work at least five (5) consecutive working days?** ☐ Yes ☐ No

*** Is this a job related illness?** ☐ Yes ☐ No

*** Will Workers' Compensation Benefits be applied for?** ☐ Yes ☐ No

Applicant's Signature	Date

Part B: To Be Completed by Physician

Beginning Date of Illness	Date Patient Able to Return to Work

Nature of Illness

If you need more space, attach an additional sheet.

☐ **MEDICAL Diagnosis**: *(Diagnosis of Emotional or Mental Illness must be completed by a psychiatrist.)*

☐ **TREATMENT PLAN:** *(Explain regimen of treatment prescribed: indicate number of visits, nature and duration of treatment, prognosis expected, # of follow-up visits & nature of treatments. Will the employee need to be off work on an intermittent basis or work a reduced work schedule? If yes, please explain.)*

ICD.9 Code _____

Date condition commenced: _____

Probable duration of condition: _____

Is employee able to perform work of any kind? ☐ **Yes** ☐ **No**

Is in-patient hospitalization required? ☐ **Yes** ☐ **No**

Is prescribed treatment/surgery urgent-emergent? ☐ **Yes** ☐ **No**

If "No" can the recommended procedure be done outside the ASD contract calendar? ☐ **Yes** ☐ **No**

Physician/Nurse Practitioner Signature(s) and Title	Date

IRS Number	Physician/Nurse Practitioner Name (Please Print)	Telephone No.

Personnel 1385 (06/07) **Return application to the Human Resources Department**