REQUEST FOR EXTENDED SICK LEAVE DAYS

Please complete this form and return to **LaWanda Hines, HR Clerk for BCISD**. An official **Extended Sick Leave Attending Physician's Statement** must also be submitted before this request can be considered. Extended Sick Leave days shall be used only for the catastrophic illness or injury of the employee or the catastrophic illness or injury of a member of the employee's immediate family. (DEC – Local).

Date: ____/____/____

Employee Name: _____

Address: _____

Telephone: _____ Campus/Dept. _____

Patient's name if different than above: _____ Relationship to employee: _____

I have or will have used all my available state and local leave, as well as any compensatory time and vacation days, as applicable.

I am requesting leave: Begin: ____/____/____ End: ____/____/____

Nature of illness or injury*: _____

Date illness began or accident occurred: ____/____/____ Date physician consulted: ____/____/____

Name, address, and phone number of attending physician: _____

Did the condition require hospitalization? Yes ____ No ____

If yes, please complete the following information:

Name of hospital: _____

Dates of confinement: Begin: ____/____/____ End: ____/____/____

I certify that the information given on this request for extended sick leave days is accurate and true.

Signature of Employee: _____ Date: _____

*** GINA NONDISCLOSURE NOTICE:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

For HR Department Use Only
Date Received: _____
Date Employee Enrolled in Catastrophic Leave Bank: _____
Date Decision Communicated to Employee: _____ Granted _____ Denied _____

TASB HR Services

EXTENDED SICK LEAVE ~ ATTENDING PHYSICIAN'S STATEMENT

EMPLOYEE INFORMATION* (to be completed by the employee).
Complete the Employee Information portion below. The attending physician **must fully complete** the remainder of the form. A request for Extended Sick Leave days will **not** be considered until the **Attending Physician's Statement** is received.

Employee Name: _____

Campus/Dept.: _____ Date: _____

Patient's Name: _____ Relationship: _____

MEDICAL CERTIFICATION* (to be completed by the attending physician)
Please complete the following information regarding the patient named above.

Describe illness or injury in lay terms: _____

_____

_____

Date of diagnosis: ____/____/____

Check all that apply:

The patient's illness, injury, or condition: ❒ is life threatening, ❒ requires in-patient hospitalization, and/or ❒ is expected to result in disability or death.

Explain the short-term prognosis: _____

_____

Explain the long-term prognosis: _____

_____

Dates of treatment: ____/____/____ End: ____/____/____

Is patient still under your care? ❒ Yes ❒ No

Hospitalization:

Name and address of hospital: _____

_____

Date admitted: ____/____/____ Date discharged: ____/____/____

Name of attending physician: _____

Address: _____

Phone: _____ Fax: _____

I certify that the information given on this Attending Physician's Statement is accurate and true.

Physician's Signature: _____ Date: _____

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