ADMINISTRATIVE & CONFIDENTIAL
(BPAA, BTU-TSP, COPA, ESMAB & PBA)
SICK BANK WITHDRAWAL APPLICATION FORM

TO BE COMPLETED BY APPLICANT

Applicant: ____ Work Location: ____

Home Address: ____

Personnel Number: _____________________ Contact/Cell Number: ____

Catastrophic Illness/Injury: ____

____

Date of Disability due to Catastrophic Illness/Injury: ____

Number of Days Requested: ___________________ Date Expected to Return to Work: ___________________________

TO BE COMPLETED BY SCHOOL SITE/OFFICE ONLY

Last Day of Work: __________________ Last Day Covered by Applicant's Sick/Personal Leave: __________________

Principal/Director Verifying Signature: ____

READ AND INITIAL

________ I authorize the sick leave bank committee to share with the district any medical information relevant to the consideration of my application which may be shared electronically or via hard copy. I also agree to release any and all medical information concerning my condition relevant to the sick leave requested.

________ I understand that I must exhaust my available accrued leave time to be eligible to withdraw sick bank days. In addition, I understand sick bank days shall not be granted if I am eligible for or receiving disability, which provides benefits ninety (90) days after I become disabled, nor shall they be granted for absences for which I am being reimbursed for loss of wages under an individual insurance policy.

________ If you anticipate you will be unable to return to work for an extended period of time, it is HIGHLY recommended that you contact the District's Leaves Department for information on applying for disability benefits and Family Medical Leave. The Leaves Department can be reached at 754-321-3130. The department's website is: http://www.browardschools.com/Page/32211

________ I understand that failure to comply with these conditions may result in a delay or denial of my application.

________________________________ Applicant's Signature

____________________ Date

SICK BANK COMMITTEE DISPOSITION

Date Application Received: ____________________ Date Action Taken: __________________________
Disposition of Application: _________ Approved _________ Denied
Number of Days Approved: ____________ Start Date: _______________ End Date: _______________
Comments: ____

____ Authorized Signature

INSTRUCTIONS FOR APPLYING FOR THE SICK BANK

Please complete the application form including your name, work location, home address, personnel number, home phone number, nature of the catastrophic illness or injury, the date when you became disabled, the number of days requested and the date you expect to return to work.

Those items in the second box are items which **you must have completed by the confidential secretary and verified by your principal/director**. It is important that these items be correct so consult with your immediate supervisor and location payroll person in order to ensure accuracy.

It is important to attach a Medical Doctor's Statement (M.D./D.O) that verifies your catastrophic illness or injury. The Medical Doctor's Statement should be on letterhead and as clear as possible to explain: 1) the nature of the catastrophic illness or injury, 2) verification that the condition prevents you from working, and 3) your anticipated return to work date. Please include an explanation of any accidental injury which might be covered by Workers' Compensation or personal insurance.

PLEASE NOTE: Sick bank days shall not be granted if you are eligible for or receiving disability, which provides benefits ninety (90) days after you become disabled.

The original, completed, signed application form and accompanying doctor's statement on letterhead should be sent to:

The School Board of Broward County, Florida
Leaves Department
Attention: Sick Leave Bank
7770 West Oakland Park Boulevard, 2nd Floor
Sunrise, FL 33351

Telephone: 754-321-3130
Fax: 754-321-3140

The Committee will be convened on your behalf and you will be notified of the outcome.