FEDERATION OF PUBLIC EMPLOYEES (FOPE)
CLERICAL/SECRETARIAL
SICK LEAVE 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:

Federation of Public Employees
Attention: Carol Nicome-Brady
1700 NW 66th Avenue Suite 100
Plantation, FL 33313

Telephone: 954-797-7575
Fax: 954-797-2922

Please Note: FOPE will forward a copy of the completed, signed application and the medical information to the Leaves Department ONLY if you have initialed the application provision that authorizes the release of your medical information. Otherwise, you must provide a copy of those materials to the Leaves Department in order to have your application processed.

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