Arlington INDEPENDENT SCHOOL DISTRICT
More Than a Remarkable Education

CATASTROPHIC SICK LEAVE BANK APPLICATION (SLB)

Definition of catastrophic illness or injury: Severe condition or combination of conditions affecting the mental or physical health of the employee (or employee's spouse or dependent child) that requires the services of a licensed practitioner for a prolonged period and that forces the employee to exhaust all paid leave time earned by that employee. Such conditions typically require prolonged hospitalization or recovery or are expected to result in disability or death.
Pre-existing conditions: SLB typically cannot be used for any medical condition for which the member was diagnosed on or before the date they first joined SLB.

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

Please initial boxes below:

☐ Pre-existing conditions are not covered.

☐ Members may initiate a request for SLB pay provided they are on Family Medical Leave (FMLA) or Temporary Disability Leave (TDL). Once protected leave status is exhausted, the employee is no longer eligible to receive SLB pay.

☐ I understand that family sick leave bank coverage is for self, legal spouse, or a dependent child under 18 years of age

☐ Requests for catastrophic sick leave bank paid days must be accompanied by medical certification that the condition meets the definition of a catastrophic illness or injury.
- Identifying the nature of the illness and/or extent of injury including a statement that the condition is not a pre-existing condition.
- Date of initial onset of this condition.
- Anticipated date when the employee will be eligible to return to work on a full or part-time basis.

☐ I understand that the deadline to apply for sick leave bank is 60 days from the first day of unpaid leave.

Date: _____Employee Name: _____Employee ID #:_____

Phone: _____Position: _____ Campus/Dept.: _____

Patient's Name: _____Relationship: ☐ Self ☐ Spouse ☐ Dependent Child
(Underage 18yrs)

Date you joined SLB: _____ Previously used SLB: ☐ Yes ☐ No When:_____

Is this claim covered by Worker's Compensation? ☐ Yes ☐ No

Last date actively worked: _____When did symptoms begin_____

Describe nature of illness, or accident: _____

Date consult: _____ Name: _____

Address: _____ Phone Number: _____

I hereby certify that the information given to the Catastrophic Sick Leave Bank program administrators is valid to the best of my knowledge and my FMLA/TDL HIPPA authorization releases medical records to the Sick Leave Bank program administrators.

_____ _____
Employee's Signature (or designate, if necessary) Date

CATASTROPHIC SICK LEAVE BANK APPLICATION (SLB)

MEDICAL CERTIFICATION* (to be completed by the attending physician)

Please complete the following information regarding the patient named above. The Catastrophic Sick Leave Bank is a voluntary program offered by the Arlington Independent School District. The bank covers members' catastrophic illnesses and injuries. The bank does not cover pre-existing conditions, elective surgeries, pregnancy, or other non-catastrophic situations. The district defines "catastrophic illness or injuries as:

DEFINITION OF CATASTROPHIC ILLNESS OR INJURY*: Severe condition or combination of conditions affecting the mental or physical health of the employee (or employee's spouse or dependent child) that requires the services of a licensed practitioner for a prolonged period and that forces the employee to exhaust all paid leave time earned by that employee. Such conditions typically require prolonged hospitalization or recovery or are expected to result in disability or death.*

PRE-EXISTING CONDITIONS: SLB typically cannot be used for any medical condition for which the member was diagnosed on or before the date they first joined SLB.

PHYSICIAN STATEMENT/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: _____/_____/_____, Is patient still under your care? ☐ Yes ☐ No

A catastrophic illness or injury is a severe condition affecting the mental or physical health of the employee or a member of the employee's immediate family and may result in disability or death.

INITIAL ALL THAT APPLIES:

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

Explain the short-term prognosis: _____

_____

Explain the long-term prognosis: _____

_____

Dates of treatment: _____/_____/_____ End: _____/_____/_____

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:_____

**Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b)*