HCEA Sick Leave Bank Initial Request

Howard County Education Association (HCEA)

5082 Dorsey Hall Drive ● Suite 102 ● Ellicott City, Maryland 21042

Telephone 410-997-3440 ● Fax 410-997-3443 ● Email HCEASLB@mseanea.org

INSTRUCTIONS: Attach Sick Leave Bank Physician's statement (2 pages) and forward all copies to HCEA.

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Please **NEATLY PRINT** all information. All sections MUST be completed.

Check one (√): ☐ Mr. ☐ Mrs. ☐ Ms.　　Check one (√): ☐ **ESP** ☐ **Certificated**　Employee ID Number _____

Last _____ First _____ MI _____

Address: _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Non-Work Email _____

School/Department _____ School Phone _____

Position _____　Employment Status: Check one (√): ☐10-mth ☐11-mth ☐12-mth

Check one (√): ☐Full-time ☐Part-time　　If Part-time, hours worked per day _____ days per week _____

Reason for this sick leave bank request _____

Was this illness/injury work related? ☐ Yes ☐ No

At this time have you applied for Disability from the State Retirement System for this condition? ☐ Yes ☐ No

　　　　If yes, date and status of application_____

Dates requested by doctor/treating physician _____ *Dates must fall within what your treating physician indicates. You are responsible for knowing when your regular sick and personal days have been exhausted.

Have you received previous sick leave bank grants? ☐ Yes ☐ No　If yes, how many? _____ Dates _____

Do you want to preserve two of your personal days?　Check one (√): ☐ Yes ☐ No　Please Note: Checking 'yes' may lead you to be without pay during the 5 day compensable wait period.　Call HCPSS payroll (410-313-6721) if you are not aware of your current leave balances.

If nothing is checked HCPSS will assume it's okay to utilize the 2 personal days, if needed.

If any portion of my application is falsified, it may result in disqualification for Sick Leave Bank grants and/or disciplinary action by my employer. By submitting this form, I certify that I have reviewed and that I am in compliance with all policies and procedures for Sick Leave Bank including disclosure of any secondary employment. Applicant should feel free to attach any relevant and/or necessary explanations to this application.

_____　　　_____

Signature of Applicant　　　　　　　　　　　　　　　　　　　Date　　　　　　　　　　03/28/2019

Office use only: Date of membership enrollment: _____

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Physician's Statement Form ● Page 1 of 2

THIS SECTION TO BE COMPLETED BY PATIENT

Patient's Name: Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned licensed medical doctor to release any information acquired during my treatment or examination. If clarification is necessary, I understand that it may be necessary to submit more medical statements at the Committee's request or I hereby authorize the Sick Leave Bank Administrator to speak directly to the doctor's office. I agree to provide the job analysis found at HCEANEA.ORG to the physician completing this form.

_____   _____
Applicant's Signature   Date

THIS SECTION TO BE COMPLETED BY *TREATING* PHYSICIAN

NOTE TO PHYSICIAN: The purpose of this application is to provide sick leave to the above-mentioned member of the HCEA-HCPSS Sick Leave Bank in case of a prolonged, incapacitating and catastrophic personal illness. This information is necessary to allow the committee to render a fair and reasonable decision whether this medical condition meets the criteria of the Sick Leave Bank. Both Physician Statement pages need to be completed.

Patient (name) _____ was under my care and unable to

work from _____ / _____ / _____ through _____ / _____ / _____. (**Dates must be completed. If end date is**

unknow, please write an estimated date the patient is expected to return to work.)

Is this patient's condition a permanent disability? ☐ Yes ☐ No   If yes, date known _____

Was surgery performed or is it scheduled to be performed?   ☐ Yes ☐ No   If yes, date of surgery _____

　　　　　If surgery was performed, the following **MUST** be completed:

　　　　　Is/Was the surgery: Check one (√) ☐ Medically advised at this time *or* ☐ Able to wait until school is
　　not in session/system break

_____
Licensed Medical Doctor's Signature

_____   _____
Licensed Medical Doctor's Name (type or print – MUST be legible)   Date

THIS PAGE TO BE COMPLETED BY *TREATING* PHYSICIAN

Please provide a complete statement of the medical diagnosis confirming the catastrophic and incapacitating nature of the condition. If it appears likely that this patient will not be able to return to this type of employment, please indicate below.

Patient's Name: Last _____ First _____ MI _____

TYPE OR PRINT LEGIBLY
Diagnosis: The physician's diagnosis, **in layman terms**, must include and confirm the **catastrophic and incapacitating** nature of this patient's condition.

_____
_____
_____
_____

Date physician diagnosed condition _____ Date treating physician last examined this patient _____

Treatment Plan: Briefly explain the treatment plan, expected duration/outcomes, including any medication adjustments and frequency of appointments and/or therapy.

_____
_____
_____
_____

Inability to Work: Please describe how this condition and its treatment inhibits the patient's ability to perform his/her professional duties during the workday. Unless the position is itinerant, this may not include driving limitations.

_____
_____
_____
_____

Date patient is anticipated to return to work. * _____ **(Must be completed and match date on page 1 of Physician's Statement Form)**

*The committee understands this may be adjusted.

_____
Licensed Medical Doctor's Signature (Please include M.D., D.O., etc.)

_____
Licensed Medical Doctor's Name (type or print – **MUST** be legible)

_____
                        Date

Both Physician Statement Forms must be completed and signed by the licensed treating ***physician.***

Required: Address of Physician (Street, City, State, Zip)
Physician's Telephone: