STILLWATER PUBLIC SCHOOLS
HUMAN RESOURCES

Sick Leave Bank, Sick Leave Sharing and Ext Sick Leave Request Form

* Per the negotiated agreement, employees must have exhausted or will exhaust all sick and personal leave to request the use of leave days to be donated by another employee.

Employee Information

Employee Name: _____

Position: _____

School Site/Department: _____

Employee Number: _____

Requesting Sick Leave due to:

☐ Employee having a severe or extraordinary illness, injury, impairment, or physical or mental condition which would result in an extended loss of time.

☐ Employee's immediate family member having a severe or extraordinary illness, injury, impairment, or physical or mental condition which would result in an extended loss of time.

Family member's name: _____

Family member's relation to me: _____

Please check all options you are requesting.

☐ **Sick Leave Bank**. I am certifying that I am an eligible member of the sick leave bank and am requesting the first 20 days of sick bank leave. Limit of 60 days requested. Must request in 20-day increments.

☐ **Sick Leave Sharing**. I am certifying that I am eligible for the District's Sick Leave Sharing. I am requesting _____ days of sick leave. 60 days limit per request.

☐ **Support Extended Sick Leave**. I am certifying that I am eligible to apply for Extended Sick Leave. I am requesting the 20 days of sick leave with a 50% deduction.

☐ **Certified Extended Sick Leave**. I am certifying that I am eligible to apply for Extended Sick Leave. I am requesting the 20 days of sick leave with a deduction equaling the cost of substitute per day.

Reason for Leave Request:

_____

_____

_____

_____

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Have you received leave from Sick Leave Bank or Sick Leaving Sharing before: _____

If so, When?

_____

Will this condition cause or likely cause you to take leave without pay or terminate employment?

_____

_____

Were you or your "immediate family member" hospitalized or provided professional home base care for this "severe" or "extraordinary" illness or condition?

_____

_____

_____

☐ I have attached a Physician's note verifying the nature of the condition and the expected duration.

I, _____, give my permission for Stillwater Public Schools' Human Resource Department to share the medical documents provided with this form and further medical documentation shared by myself to the Stillwater Public School's Administration and Board of Education.

_____ _____
Employee Signature Date

District's Verification and Approval

☐ Approved

☐ Denied

_____ _____
Signature and Position of Appointed Authority Date