

**CLAY COUNTY SCHOOLS  
SICK LEAVE BANK WITHDRAWAL APPLICATION**

I – APPLICANT

Applicant: _____	Work Location: _____
Address: _____	Home Phone No: _____
_____	Social Security No: _____
Date Submitted: _____	Last Day of Work: _____
Enrolled S.L.B. Yes ___ No ___	Date Leave Began: _____
All Sick Leave has been used: Yes ___ No ___	Sick Leave Expired on: _____
Illness or Injury in Line of Duty Leave: Yes ___ No ___	
Drawing Disability Payments: Yes ___ No ___	
Drawing Worker's Compensation: Yes ___ No ___	
Estimated Additional Sick Days Needed: _____	
Nature of Illness or Injury: _____	
Attending Physician: _____	
Comments or Supporting Information: _____	
_____	
Date Due to Return to Work: _____	
<p>I certify that the above information is correct and true. I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim, to the Clay County Sick Leave Bank Committee.</p>	
(A Photostat of this authorization shall be as valid as the original) _____	
Applicant's Signature	
Forward all copies to the Business Affairs Division with Physician statement attached.	

II– CLAY COUNTY SICK LEAVE BANK COMMITTEE DISPOSITION

Application Received on: _____	Action Taken On: _____	
Application: Approved: _____	Denied: _____	
Credit: _____ with _____ day(s) from the Sick Leave Bank.		
Effective Date: _____	Comments: _____	
_____		
Authorized Signatures (3 Required):		
1. _____	2. _____	3. _____

**PHYSICIAN FORM**

APPLICANT: Have this form completed by attending physician and return with the Sick Leave Bank Application. FORM MUST BE COMPLETELY FILLED OUT before application will be considered.

PHYSICIAN: Complete this form and return it to the patient. If you have questions, please contact the Sick Leave Bank Committee, Clay County Education Association, c/o Nancy Sirmons, Chair, Thunderbolt Elementary, 2020 Thunderbolt Road, Fleming Island, FL 32003.

APPLICANT INFORMATION

PHYSICIAN INFORMATION

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

Phone No: \_\_\_\_\_

M.D. \_\_\_\_\_ D.O. \_\_\_\_\_

Specialty \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Is patient now physically disabled? \_\_\_\_\_

Prescribed treatment: \_\_\_\_\_

\_\_\_\_\_

Was patient previously treated for this problem? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_

Estimate date patient will be physically able to return to full time work: \_\_\_\_\_

Anticipated restrictions upon return to work: \_\_\_\_\_

\_\_\_\_\_

For maternity leave, please state estimated due date: \_\_\_\_\_

Please note any other pertinent information that may be helpful to the Sick Leave Bank Committee in making a decision about granting days to this patient: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Physician