# DEARBORN FEDERATION OF SCHOOL EMPLOYEES
# SICK LEAVE BANK APPLICATION

Name:

Address:

Location:

Telephone Number: _____ Social Security #:

Have you ever worked part-time?_____ # of years:_____ # of hrs. Per day

Reason for Absence:

Date Absence Began: _____ 20____, Date of Anticipated Return:_____ 20

Date Sick Days will be Exhausted: _____ 20 _____ (you must have used a minimum of 15 sick, vacation and personal business days to cover first 15 days of illness)

Have you applied to S.L.B. Previously? Yes No

Prior Illnesses that contributed to Sick Bank Depletion:

Name, address and telephone number of an independent licensed health care professional who will submit a completed S.L.B. Physician referral form.

Name Address Telephone

The Sick Bank has never been intended to replace the employee=s responsibility to use their personal sick bank prudently.

*Promissory Note*

*I agree that during the time I am a recipient of benefits from the Sick Leave Bank, I shall not be gainfully employed, full or part-time. I understand that such employment would result in my reimbursement to the district of any monies paid out according to the number of days worked in the other employment.*

_____
Signature of applicant

**Please read the attached critera, complete this application, and return to the Human Resources Department, Dearborn Public Schools, 18700 Audette, Dearborn, MI 48124, accompanied by an independent licensed health care professional=s statement.**

This section to be filled out by Human Resources

Sick Leave Bank Member _____ yes _____ no

This application has been _____granted _____denied

_____ new _____ renewal

_____ _____
Signature of S.L.B. Chairperson Meeting Date

*Applicant=s Name* _____

**PHYSICIAN REFERRAL FORM FOR**
**DEARBORN FEDERATION OF SCHOOL EMPLOYEES SICK LEAVE BANK**

1. Describe illness or injury suffered _____
_____
_____

2. Diagnosis _____
_____
_____

3. Prognosis _____
_____
_____

4. Treatment Plan _____
_____
_____

5. Expected Convalescence _____
_____
_____

6. Date of anticipated return to work _____ 20_____

_____ _____
Date Signature of Health Care Provider

Name, address and telephone number of licensed health care professional:
_____
_____
_____

***Please feel free to attach any pertinent information.***