DEARBORN FEDERATION OF TEACHERS
CENTRAL SICK LEAVE BANK APPLICATION

Name: _____

Address: _____

Location: _____

Telephone Number:_____Social Security #: _____

School_____

Reason for Absence:_____

_____

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

Date Sick Days will be Exhausted: _____ 20 _____ (you must be absent for a minimum of ten consecutive days)

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

Name, address and telephone number of two (2) independent licensed health care professionals, at least one of who shall be licensed to practice medicine, who will submit a completed C.S.L.B. Physician referral form.

Name Address Telephone

1. _____

2. _____

Promissory Note

I agree that during the time I am a recipient of benefits from the Central 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. **Yes, I have read the criteria**

_____
Signature of applicant

Please complete this application, and return to the Human Resources Department, Dearborn Public Schools, 18700 Audette, Dearborn, MI 48124, accompanied by two (2) independent licensed health care professionals' statements.

This section to be filled out by Human Resources

This application has been _____granted _____denied

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

_____ new _____ renewal

Applicant's Name _____

PHYSICIAN REFERRAL FORM
FOR DEARBORN FEDERATION OF TEACHERS CENTRAL SICK LEAVE BANK

The purpose of Central Sick Bank is to assist employees only in the event of catastrophic illness. Its intent has been to include occurrences such as: 1) massive heart attack, 2) cancer, 3) serious injury that is potentially permanently disabling, or 4) life threatening illness. Days are granted from the "Bank" only following use of personal sick days.

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

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.

Applicant's Name _____

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Date Signature of Health Care Provider

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

Please feel free to attach any pertinent information.