DEARBORN FEDERATION OF SCHOOL EMPLOYEES
CENTRAL 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 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 a licensed health care professional who shall be licensed to practice medicine will submit a completed C.S.L.B. Physician referral form.

Name Address Telephone

_____

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 a 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 _____renewaal

Updated 12/8/2021

Applicant's Name _____

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

The purpose of Central Sick Bank is to assist employees only in the event of catastrophic 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.