

**DEARBORN FEDERATION OF TEACHERS
CENTRAL SICK LEAVE BANK APPLICATION**

Name: _____

Address: _____

Location: _____

Telephone Number: _____

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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