

**ASSOCIATION OF DEARBORN SCHOOL  
ADMINISTRATORS 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 ASSOCIATION OF DEARBORN SCHOOL ADMINISTRATORS 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 \_\_\_\_\_

**PHYSICIAN REFERRAL FORM FOR ASSOCIATION OF DEARBORN SCHOOL ADMINISTRATORS 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.*