

**A.I.S.D. CATASTROPHIC SICK LEAVE BANK  
APPLICATION**

Date of Application: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip \_\_\_\_\_ Phone No.: \_\_\_\_\_

Home School: \_\_\_\_\_ Position: \_\_\_\_\_

Designated Contact (if helping make application): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date Employed by AISD: \_\_\_\_\_ Date you joined Bank \_\_\_\_\_

Is this claim covered by Workmen's Compensation? Yes \_\_\_\_\_ No \_\_\_\_\_

School Location: \_\_\_\_\_ Current Assignment: \_\_\_\_\_

Have you used Bank previously? \_\_\_\_\_ When? \_\_\_\_\_

Last date actively worked: \_\_\_\_\_ When did symptoms begin? \_\_\_\_\_

Describe nature of illness, or accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date physician consulted: \_\_\_\_\_

Name of attending physician(s): \_\_\_\_\_

Address of physician(s): \_\_\_\_\_

Phone number of physician(s): \_\_\_\_\_

I hereby certify that the information given to the Catastrophic Sick Leave Bank Committee of Directors is valid to the best of my knowledge, and I authorize release of medical records to the Sick Leave Bank committee physician.

\_\_\_\_\_  
Employee's Signature (or Designate, if necessary)

\_\_\_\_\_  
Date

**THE FOLLOWING MUST ACCOMPANY THE APPLICATION:**

A statement or form signed by an attending physician which provides the following information:

1. Identifying the nature of the illness and/or extent of injury including a statement that the condition is not a pre-existing condition.
2. Date of initial onset of this particular condition.
3. Anticipated date when the employee will be eligible to return to work on a full- or part-time basis.

**The application cannot be considered until all items are available.**

Dear Physician:

The Catastrophic Sick Leave Bank is a voluntary program offered by the Arlington Independent School District. The Bank covers members' catastrophic illnesses and injuries. The Bank does not cover pre-existing conditions, elective surgeries, pregnancy, or other non-catastrophic situations.

To be eligible for coverage, the employee first must expend all personal leave. The employee or designee then must submit an Application for Benefits form along with medical documentation. Each application is considered solely on the information provided by the employee and their doctor.

**In order for your patient's application to be considered by the Bank, it is imperative that the following information be provided in a brief letter from any doctor providing services:**

- Diagnosis: What is the nature of the illness or injury?
- Date of onset: When did the symptoms first begin?
- Pre-existing Nature of Illness/Injury: Is this an exacerbation or recurrence of a previous injury or illness? If so, what was the date of onset of the original illness or injury?
- Expected date of return: When will the patient be able to return to work? Will that be on a limited basis?
- Dates of hospitalization: What are the inclusive dates of hospitalization (if applicable)?
- Severity of illness or injury: What treatment is required? How long do you anticipate this treatment continuing? What are the limits of the patient's activity? This is needed to make a determination as to whether the illness or injury meets the Bank's definition of catastrophic.

All applications are reviewed monthly to determine continuing coverage; therefore an updated letter from the medical provider must be submitted each month.

Sincerely,

AISD Catastrophic Sick Leave Bank