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 the required physician statement form is received.

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 must submit an Application 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 or 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/physician statement from the medical provider must be submitted each month.

Sincerely,

AISD Catastrophic Sick Leave Bank Committee of Directors

CATASTROPHIC SICK LEAVE BANK PHYSICIAN'S STATEMENT FORM

EMPLOYEE INFORMATION* (to be completed by the employee).
Complete the Employee Information portion below. The attending physician must fully complete the remainder of the form. A request for sick leave bank days will **not** be considered until the **Attending Physician's Statement** is received.

Employee Name: _____

Campus/Dept.: _____Date: _____

Patient's Name: _____ Relationship: _____

MEDICAL CERTIFICATION* (to be completed by the attending physician)

Please complete the following information regarding the patient named above. 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. The district defines "catastrophic illness or injuries" as:

"A catastrophic illness or injury is a severe condition or combination of conditions affecting the mental or physical health of the employee that require the services of a licensed practitioner for a prolonged period of time and that forces the employee to exhaust all leave time earned by that employee and to lose compensation from the District."

If it is in your professional medical opinion that the employee's illness or injury is catastrophic as defined by the definition above please complete the form below.

Describe illness or injury in lay terms: _____

_____

_____

Date of diagnosis: _____/_____/_____

Check all that apply:

The patient's illness, injury, or condition: ❒ is life threatening, ❒ requires in-patient hospitalization, and/or ❒ is expected to result in permanent disability or death.

Explain the short-term prognosis: _____

_____

Explain the long-term prognosis: _____

_____

Dates of treatment: _____/_____/_____ End: _____/_____/_____

Is patient still under your care? ❒ Yes ❒ No

Hospitalization:

Name and address of hospital: _____

_____

Date admitted: _____/_____/_____ Date discharged: _____/_____/_____

Name of attending physician: _____

Arlington
INDEPENDENT SCHOOL DISTRICT
More Than a Remarkable Education

Address: _____

Phone: _____Fax: _____

I certify that the information given on this Attending Physician's Statement is accurate and true.

Physician's Signature:_____Date: _____

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* **GINA NONDISCLOSURE NOTICE:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.