NEA/NARRAGANSETT
SICK LEAVE REQUEST FORM

Section A **SECTION A TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)**

Name_____ School Identification Number_____
School/Department_____Position_____
Address_____
City State Zip Code

Telephone: Home_____Cell_____Work_____
Date of Last Day Worked_____ Number of Leave Days Requested_____
Describe the nature of your illness or injury and reason that returning to work is not possible:_____
_____
_____

1. Only teachers who are members of the Sick Leave Bank are eligible for to apply for benefits
2. To draw days from the bank a member must first exhaust their accumulated sick days (all but ten)
3. The initial grant of approved sick leave time shall not exceed twenty (20) days (a one month period), to be distributed in ten(10) day (one pay period) increments by central office.
4. Upon completion of the initial twenty (20) day sick leave grant, the member may request an extension of sick leave days upon demonstration of need and further medical documentation. In no event will a member be granted more than 180 days total for any one illness or injury.
5. All leave granted, but not used by a requestor, will be returned to the members donating the days.
6. Decisions of the Sick Bank Committee shall be final and binding and not subject to the grievance procedure

Physician's Name_____Telephone Number_____Fax_____
Address_____
Street City State Zip

Authorization: I have read and agree to abide by the Terms, Conditions, and Instructions provided in the above information and in the Sick Bank Policy. I certify that supporting documents are true and correct. I authorize my Physician(s) to release information relating to my catastrophic illness/injury to the Narragansett Teacher Sick Bank Committee. I understand that misrepresentation or falsification will subject me to penalties and loss of benefits. I hereby release the Narragansett Board of Education and its employees, agents, and Sick Leave Committee for any liability relative to decisions rendered.

_____ _____
Signature of Employee or Designee Date

Submit all copies to your building Sick Bank Committee Member

Section B **SECTION B TO BE COMPLETED BY SICK BANK COMMITTEE ONLY**

DATE REQUEST RECEIVED_____PHYSICIAN'S STATEMENT ATTACHED YES_____NO_____
MEMBER'S ACCUMULATED LEAVE ENDED OR ENDS_____
DATE OF FIRST DAY OF WORK MISSED FOR THIS ILLNESS/INJURY_____
DATE OF LAST DAY WORKED_____NUMBER OF DAYS DRAWN FROM PROGRAM IN PAST FOR THIS ILLNESS/INJURY_____

REQUEST GRANTED_____NUMBER OF DAYS GRANTED FROM SICK BANK PROGRAM_____
REQUEST DENIED_____REASON DENIED _____
_____

SIGNATURE OF SICK BANK COMMITTEE MEMBERS
_____

_____

NEA/NARRAGANSETT

PHYSICIAN'S STATEMENT

Patient's Name: _____D.O.B._____

I authorize you, as my attending physician, to release the following medical information about me to a representative of the NEA/Narragansett Sick Bank Committee.

_____ _____

Patient Signature Date Signed

Dear Doctor

The NEA/Narragansett Teacher Sick Leave Bank is a voluntary program where members donate their own sick time to assist a member with a catastrophic illness or injury that requires extended hospitalization, treatment, and/or home confinement beyond their own personal accumulated sick time. Your patient is requesting members provide sick leave time for their current illness/injury. To assist us in making a determination of eligibility please complete the following questions:

1. Are you the regular health care provider for this patient? Ye☐ No☐

2. Is this patient presently under your care? ☐ Yes ☐ No

3. Describe the illness, injury, or condition for which you are treating the patient:
   _____
   _____
   _____

4. 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? _____

5. What treatment is required?
   _____

6. _____

7. Date(s)of treatments_____
8. Date(s) of incapacity to work due to the above illness, injury, or condition: _____
9. If patient was hospitalized for the above illness, injury, or condition:
   Date(s) and name of hospital_____
10. What are the limits of the patient's activity? _____
    _____
11. Is the patient on home confinement?_____
12. Date on which patient is expected to be released to return to work:_____
13. Would it be possible to consider a part-time/limited return to work:_____

*The Sick Leave Bank requires physician recertification of accident, illness, treatment for every 20 days out of work (i.e. every four weeks).

_____ _____

Physician/Health Care Provider's Name Physician/Health Care provider's Address

_____ _____ _____ _____

Physician/Health Care Provider's Signature Date Phone Number Fax Number