SICK LEAVE POOL APPLICATION

This entire application **MUST** be completed for consideration by the Sick Leave Pool Committee.

Case # ________
Date of Review ________
Approved ________
Denied ________
# of Days Awarded ________
Total Days Granted to Date ________
For internal use only

Please print all information.

Date of Application: ________________________

Full Name: ____

Address: ____Phone: _______________

City: ________________________State: ___________Zip: ___________

Social Security #: _______________________

Last Day Worked: _________________

Date Sick Leave and Personal Leave Days Run Out: ________________________________

Have you previously applied and been approved days from the Sick Leave Pool:

____Yes____ No

SICK LEAVE USAGE:
Summarize any extensive use of sick leave, resulting in the depletion of your sick leave days.
(add additional pages if necessary)

____
____
____
____
____
____

This claim is due to: ____ Illness ____ Injury

ILLNESS (If injury, skip this section.)
When did illness first occur? __________________________

Explain history of the illness (Attach additional page(s) if necessary).

____
____
____
____
____
____
____

INJURY

Date of injury: ___________________________

Was injury the result of an accident? ____ Yes ____No

Was the injury work related? ____ Yes____ No

State the cause of the injury (Attach additional page(s) if necessary).

____

____

____

____

State medical problems resulting from injury (Attach additional page(s) if necessary).

____

____

____

____

MEDICAL DOCUMENTATION

Name of specialist/attending physician: ____

Name of hospital: ____

Admission date: __________________ Discharge date: _______________________

WORKERS COMPENSATION

Is there possible workers compensation liability? ____ Yes ____ No

Current status of workers compensation claim: ____Approved ____Denied

____ Pending ____ Not Filed

Your physician must complete pages 3 & 4 and return it to our office prior to the application due date in order for your application to be considered.

I hereby certify that all information presented to the Sick Leave Pool Committee is true, accurate, and complete to the best of my knowledge. I also understand the Sick Leave Pool Committee may require additional information prior to a final decision being made on this application.

_________________________________ _______________________________

Signature Date

SICK LEAVE POOL
PHYSICIAN'S STATEMENT

Please print all information.

Patient's Name: ____

Address: ____Phone:________________

City: _______________________State: ________Zip: __________________

****The following physician's statement is to be completed by the physician only. Any information added to or altered by the applicant may result in immediate disqualification****

Specialist/Attending Physician's Name: ____

Address: ____Phone: ________________

City: _______________________State: ________Zip: __________________

Please explain the nature of the illness or injury (Attached additional page(s) if necessary).

____

____

____

____

____

____

____

____

What is the plan of treatment? ____

____

____

____

____

____

____

____

If surgery is planned, can it be delayed until the employee's Winter/Spring/Track break?
____ Yes____ No

If no, why not? ____
____
____
____

Does the illness or injury described above prevent the patient from working?
____ Yes____ No

If yes, what is the medical **treatment** that prevents this patient from going back to work?
____
____
____
____
____

Patient can return to work on (month/day/year): ____
(***Specified date is required***)

Physician's Signature: ___________________________________ Date: ________________

Physician:

Upon completion of this form, please return it promptly to the CCEA/CCSD Sick Leave Pool Committee via any of the following methods. Please do not return it to the patient.

Mail

4230 McLeod Dr.
Las Vegas, NV. 89121

Fax
702-866-6134, Attention: Sick Leave Committee
Email
aammons@ccea-nv.org