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

SICK LEAVE POOL APPLICATION

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

Please print all information.

Date of Application: _____

Hire Date: _____

Full Name: _____

Address: _____Phone: _____

City: _____State: _____Zip: _____

Social Security #: _____

Are you an employee with add-on days?____ Yes ____ No

If yes, how many? _____

Number of Days Requested: _____

Last Day Worked: _____

Specific Dates Requested: _____

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 family/general physician(s): _____

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

<u>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.</u>

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
mhernandez@ccea-nv.org