

SICK LEAVE POOL APPLICATION

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

(Return date is required)

Please print all information.

Date of Application: _____

Date of Hire: _____

Full Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

CCSD ID #: _____

Last Day Worked: _____

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).

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

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

Is Surgery required? ____ Yes ____ No

Can it be delayed until the employee's Winter/Spring/Summer Break? ____ Yes ____ No

If no, what is the reason?

(Return date is required)

Patient can return to work on (month/day/year): _____

(Return date is required)

Physician's Signature: _____ Date: _____

Physician:

(Return date is required)

Upon completion of this form, please return it promptly to the CCEA/CCSD Sick Leave Pool Committee via any of the following methods.

Fax

702-866-6134, Attention: Sick Leave Committee

Email

slp@ccea-nv.org

aammons@ccea-nv.org