Case # _____
Date of Review _____
Approved _____
Denied _____
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.
***(The return date is required)***

***Please print all the 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 the history of the illness (Attach additional page(s) if necessary).

_____
_____
_____
_____
_____
_____
_____
_____
_____

**INJURY**

Date of injury: _____

Was the 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 worker's compensation liability? ____ Yes ____ No

Current status of workers compensation claim: ____Approved ____Denied

____ Pending ____ Not Filed

In order for your application to be considered, your physician must complete pages 3 and 4 and return them to our office before the application due date.

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 before making a final decision on this application.

_____ _____

Signature Date

# SICK LEAVE POOL
# PHYSICIAN'S STATEMENT

***(The return date is required)***

***Please print all the information.***

Patient's Name: _____

Address: _____

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).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

If yes, what is the **medical treatment**? _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check the following
_____ Intermittent Leave
_____ Full Release Leave

Is Surgery required? ____ Yes____ No
Can it be delayed until the employee's Winter/Spring/Summer Break? ____ Yes____ No

If not, what is the reason?

***(The 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