WCEA SICK LEAVE BANK REQUEST

Incomplete forms will be returned.

Mail, fax or deliver this completed form to:
WCEA Sick Leave Bank Committee
1302 Old Ocean City Road
Salisbury, MD 21804
Phone: 410-749-2491 | Fax: 410-860-2706

Name: _____ Date: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Job Title & Responsibilities:

_____

_____

School: _____

Please indicate **all** of the following which apply to your current condition:

- ☐ Illness
- ☐ Pre-existing condition
- ☐ Injury
- ☐ Work-related injury
- ☐ Injury due to a vehicular accident
- ☐ Meets the conditions for Disability

At this time, have you applied for Disability for this condition?

- ☐ Yes
- ☐ No

Describe in your own words your current condition as it relates to your inability to return to work at this time:

_____

_____

_____

_____

FOR WCEA SICK LEAVE BANK COMMITTEE USE ONLY

First date out on leave for this illness/occurrence: _____

Date personal and sick leave expired: _____

Committee member's initials: _____ _____ _____

Date approved/denied: _____ _____ _____

Approved (yes/no): _____ _____ _____

Comments: _____

_____

_____

Committee approved (yes/no): _____ Date: _____

Grant dates: From _____ To _____

PHYSICIAN'S STATEMENT

To be completed by the patient:

Patient's Name (print): _____

Authorization to release information: I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment. It is further authorized that the information contained herein may be forwarded to the physician(s) designated by the WCEA Sick Leave Bank Committee, if required.

_____

Patient signature

To be completed by the physician:

Dear Doctor:
Please provide sufficient medical information to allow the Wicomico County Education Association Sick Leave Bank Committee to render a fair and reasonable decision in determining how this patient's condition impacts his/her professional responsibilities. You may submit a narrative or photocopies of your records with this form.

Medical Diagnosis: Please give a clear and complete statement of your medical diagnosis which confirms the catastrophic or incapacitating nature of this patient's condition.

_____

_____

_____

Treatment Plan: Breifly explain the treatment plan, including any prescriptions and therapy.

_____

_____

_____

Inability to Work: Please describe how this condition and its treatment inhibits the patient's ability to perform his/her professional duties.

_____

_____

_____

Anticipated date to return to work is _____. **This must be a complete date**. The patient will not be held to this date. It may be changed later if the situation changes. We are looking for the physician's best anticipated date at this time.

Physician's Name (please print legibly): _____

Physician's Signature: _____

MUST be the actual physician's signature (no stamps, no substitutes, no assistants)

Date: _____ Physician's Office/Group: _____