

**Rio Grande City Consolidated Independent School District  
REQUEST FOR DAYS FROM SICK LEAVE BANK**

Member's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_  
Position/Assignment: \_\_\_\_\_ Campus/Dept.: \_\_\_\_\_  
Number of years employed by Rio Grande City C.I.S.D.: \_\_\_\_\_  
I certify that I have donated two (2) or more days of my available local and/ or state sick leave to the Sick Leave Bank and have been a member since (date) \_\_\_\_\_.

**ALL FIVE CRITERIA MUST BE IN PLACE IN REQUESTING DAYS FROM THE SICK LEAVE BANK:**

- I am a member of the Sick Leave Bank.
- I have exhausted all my available state leave, local leave, vacation days accrued and extended leave.
- I am experiencing a catastrophic illness/injury, and I am unable to return to work due to this medical condition.
- I am attaching the Attending Physician's Statement form as verification of my medical condition.
- I verify that I am not receiving monies from any other insurance benefit or workers' compensation act.

**NUMBER OF SICK LEAVE BANK (SLB) DAYS REQUESTED:**

Number of days requested from SLB: \_\_\_\_\_  
Sick Leave Bank days should begin (month/date/year): \_\_\_\_\_  
Number of SLB days used beginning Sept. 1 of current year: \_\_\_\_\_

**DESCRIPTION OF ILLNESS OR INJURY:**

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SICK LEAVE BANK COMMITTEE DECISION:**

\_\_\_\_ Approved Sick Leave Bank Days for \_\_\_\_ days.  
\_\_\_\_ NOT Approved  
\_\_\_\_ Other

Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
(Committee Chairperson)

Signature for Processing ONLY: \_\_\_\_\_  
(Executive Officer)

White Copy -Personnel  
Yellow Copy -Employee  
Pink Copy -Supervisor

**Rio Grande City Consolidated Independent School District  
SICK LEAVE BANK PHYSICIAN'S STATEMENT**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No. : \_\_\_\_\_

Name of Rio Grande City C.I.S. D. employee: \_\_\_\_\_

Nature of Illness or Injury:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Hospitalization, if any, and name and address of hospital:

Date admitted: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date discharged: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Is the patient still under your care? \_\_\_\_ YES \_\_\_\_ NO

Date patient can return to work: \_\_\_\_\_

\_\_\_\_\_  
(Typed or Printed Name of Physician)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Physician: no rubber stamp please)