

Queen Anne's County Education Association
Submit request Sick Leave Bank form to:
Sick Leave Committee % Mary Meehan,
CMS through BOE mail or electronically to:
mary.meehan@qacps.org

Name Employee ID#

Address & Phone Number

Position school/work site location

Reason for your request: _____

Number of days requested from the bank _____.

Specific dates of days required _____ (You are responsible for knowing when your regular and personal days have been exhausted.)

This information along with your doctor's medical statement will be reviewed by the QACEA Sick Leave Bank Committee. Guidelines are posted on the QACEA website, www.qaceea.org

Signature of Applicant and Date

Queen Anne's County Education Association
Sick Leave Bank Medical Doctor's Statement

Patient's Name and Address Position

Authorization to Release Information: I hereby authorize the undersigned licensed medical doctor to release any information acquired in the course of my treatment or examination. If detailed information is not provided, I understand it may be necessary to submit more medical statements at the Committee's request.

I understand that failure to submit sufficient information may result in denial of this request.

Signature of Applicant and Date

The following is to be completed by a licensed medical doctor. Note to Physician: The purpose of this application is to provide sick leave to the previously mentioned member of the QACEA Sick Leave Bank in case of **prolonged, incapacitating, and catastrophic personal illness**. The Sick Leave Bank is a contribution of days from its members. In order to protect all members of the Sick Leave Bank, it is necessary for the Committee to have specific information if you consider the patient's disability to be **catastrophic**. This will allow the committee to render a fair and reasonable decision whether or not this meets the criteria as defined "herein."

Patient _____ was under my care and unable to work from _____ through _____.

Date patient should be able to return to work: (If the exact date is not known, give an approximate date)

Please provide, **in layman's language**, detailed information explaining why the patient is unable to perform their duties. **Please include a brief description of the illness, medical treatment plan, and current condition.** This information will allow the Committee to render a fair and reasonable decision regarding eligibility. **Please attach the information to this form.**

(Licensed Medical Doctor's Name - Please type)

Licensed Medical Doctor's Signature

Address

Date

Please return this form to the patient for submission to the Sick Leave Bank Committee