Dennis-Yarmouth Regional School District
SICK LEAVE BANK
APPLICATION FORM

Applicant:

Name _____ School _____ Position _____

Address _____ Telephone _____

Reason for Request: _____

_____

_____

_____

Total number of days requested: _____ (maximum of 30 work days per request) _____

Length of Service with the District

I understand that I will use all available personal sick leave and personal days before I use days granted by the Sick Bank Committee. I also understand that any days borrowed from the bank will be deducted from my accumulated sick leave before any payment for unused sick leave is made to me upon my separation from service and, consistant with my union affiliation, borrowed days may be deducted from my annual allotment.

Date _____ Applicant's Signature _____

Please return this form to: Chair of the Sick Bank Committee, c/o Dennis-Yarmouth Regional School District, 296 Station Avenue, South Yarmouth, MA 02664. The attached Physician's Statement must also be submitted prior to processing. This application and related material will be kept by the District, separate from the applicant's personnel records.

For Sick Bank Committee Use

Date Considered _____ Disapproved _____ Approved _____ Up to _____ Days

Remarks: _____

_____

_____

Length of Request: _____ start date _____ end date

Date of Notification of Committee Action _____ Signature _____

Dennis-Yarmouth Regional School District
Physician's Statement

Employee's Name _____ Position _____

I hereby authorize _____ to provide information to the Dennis-Yarmouth
name of physician

Regional School District and/or Chair of the Sick Bank Committee regarding an application for sick bank time . This information may be shared with members of the appropriate D-Y Reg. School District Sick Bank Committee.

_____
Employee's Signature

Physician's Name _____ Address _____

Telephone # _____ E-mail address _____ Fax # _____

1) I last examined the above named patient on: _____

2) Anticipated dates of disability from: _____ to: _____

3) Treatment and/or surgery is/are:

_____ Medically necessary at this time

_____ Medically necessary but non-emergency

_____ Elective

4) Nature of illness or injury and prognosis (please include any accommodations or restrictions which will be required upon the employee's return to work):

_____

_____

_____

_____

Physician's Signature _____ Date _____

Please return this completed form to:

Chair of the Sick Bank Committee
c/o Dennis-Yarmouth Regional School District
296 Station Avenue
South Yarmouth, MA 02664

over

Dennis-Yarmouth Regional School District
AUTHORIZATION FORM
FOR THE USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

I authorize the use and/or disclosure of my protected health information IPHI) as described below:

1. My authorization applies to medical information relevant to my request for days from the sick bank. Only this information may be used and/or disclosed pursuant to this authorization:

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

   _____

   _____

3. I authorize the Dennis-Yarmouth Regional School District Personnel Department and the Dennis-Yarmouth Regional School District Sick Bank Committee to receive my protected health information.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (in the form of a letter). I am aware that my revocation is not effective to the extent that the persons I have authorized to use and /or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon _____(insert date or an event that triggers expiration).

7. I further understand that treatment, payment, enrollment, or eligibility for benefits may -not be conditioned upon my signing an authorization.

I hereby certify that I have received a copy of this authorization.

_____ _____
Signature Date

_____
Name

_____ _____
Name of Personal Representative Relationship to Patient

over