

CATASTROPHIC SICK LEAVE APPROVAL FORM

WINSTON COUNTY BOARD OF EDUCATION

Double Springs, Alabama

Section I: Employee Information

Name of Employee _____

Home Address _____

Home Address _____

S. S. No. _____ Schl/Work Site Phone No. _____

Note: The employee must be a member of the Winston County School District SLB.

Section II: Description of Illness/Injury

Note: This section should be completed by the employee requesting to be granted approval for catastrophic sick leave.

A description of my illness/injury is as follows: _____

Employee's Signature

Date

Section III: Attending Physician's Statement (Required)

Note: A statement from the attending physician attesting to the need for the employee requesting catastrophic leave to be placed on extended leave.

Name of Physician _____

Business Address _____

Business Address _____

Business Phone Number _____

Physician's Statement (may be attached or written) _____

Based on my professional opinion, I estimate that the person whose name is shown in Section I above will need to be away from his/her employment for _____ days, weeks (circle one).

Physician's Signature

Date

Section IV: Board Action

Recommended by Superintendent: Yes ____ No ____ Date _____

Approved by Board: Yes ____ No ____ Date _____

Directions: Complete and return this form to the Superintendent's Office.