WINSTON COUNTY SCHOOLS
CATASTROPHIC ILLNESS
QUALIFICATION FORM

_____ SELF
_____ FAMILY MEMBER
(Specify Name & Relationship)

_____

EMPLOYEE SECTION

Employee Name _____ SS# _____ School _____

Support Personnel _____

Certified Personnel _____ Position _____

TYPE OF ILLNESS _____

_____

_____

_____ _____

DATE EMPLOYEE'S SIGNATURE

PHYSICIAN STATEMENT

_____

DATE

DIAGNOSIS _____

_____

_____

Estimated length of time to be off work due to illness _____

_____

PHYSICIAN'S SIGNATURE

APPROVAL: Yes _____ No ___

_____ _____

DATE SICK LEAVE BANK CHAIRPERSON

Copies: White
Pink
Yellow