EPISD EMPLOYEE BENEFITS

Catastrophic Sick Leave Bank Request Form

Employee Name: _____ Teams ID: _____

Address: _____ Phone #: _____

City/state/zip code: _____ Campus/Department: _____

I request consideration for approval of Catastrophic Sick Leave Bank Days for the following reason(s):

_____

_____

_____

First date of absence due to this condition: _____

My accumulated leave days will be exhausted as of: _____
(Accumulated leave balances do not include forwarded days issued on July 1st, which have not been earned)

☐ This is my initial request

☐ I have already received 30 days from the catastrophic sick leave bank. This is an additional request.

I am requesting CSL days as of _____

Any leave days given to a contributor shall be coordinated with any collateral benefits being received by the contributor, so that the sum of the amount of collateral benefits and the amount of the sick leave benefits received does not exceed pre-illness or pre-injury rate of pay.

☐ I have the SunLife disability product. I understand SunLife is a collateral benefit and that payment from the CSL will be offset by my daily SunLife disability rate.

☐ I do not have the SunLife disability product.

This completed application must be accompanied by medical certification signed by a licensed physician.

Signature _____ Date _____

FOR DISTRICT USE ONLY: SunLife Disability: _____ / _____ Worker's Compensation: _____

Accumulated leave exhausted on: _____

Approved by:

_____ Date: _____

Comments:

_____

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