COMANCHE INDEPENDENT SCHOOL DISTRICT

TO THE ATTENDING PHYSICIAN:

Patient: ______________________________

Employee ID#: _________________________

Your patient is requesting sick leave benefits from the Comanche Independent School District, which may afford the patient payment for a specific number of days lost from work.

Prior to approving any payment for days lost, a physician's statement is required concerning the patient's illness.

Please complete the attached form and return it to:

COMANCHE ISD
ATTN: HUMAN RESOURCES DIRECTOR
1414 N. AUSTIN
COMANCHE, TX 76442

This form may be given to the patient or mailed directly to Comanche ISD. If you have any questions concerning this request, please feel free to call me at 325-356-2727.

Respectfully,

Kathy Herring
Director of Finance
Comanche ISD

I, ____________________, authorize Dr. __________________, to release information regarding results of the medical examination to Comanche Independent School District ("CISD") and I allow CISD's Sick Leave Pool Committee to discuss my medical condition and review my medical records, if required.

____
Signature

____
Printed Name

____
Date

COMANCHE INDEPENDENT SCHOOL DISTRICT
CATASTROPHIC SICK LEAVE POOL
ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: ______________________ Relation to Employee: ______________________

Employee ID# ______________________ Campus/Dept.: ______________________

Description of Sickness or Injury: ____

____

____

Nature of sickness or injury: Under the Comanche ISD Sick Leave Pool Procedures as attached, is patient's condition a catastrophic illness or injury? [ ] Yes [ ] No See attached form.

Date of Diagnosis: ____

Dates of Treatment: ____

____

____

If hospitalized please complete the following information:

Date admitted: ______________________ Date discharged: ______________________

Name of hospital: ____

Address of hospital: ____

To your knowledge, what was the earliest day the patient was treated for this condition? __________

____

Is the patient still under your care? Yes __________ No __________

How long was or will the patient be unable to work? ______________________________

____

____

Date patient can return to work: ____

I certify that the information provide on this Statement is true and correct.

______________________________ ______________________
Physician's Signature Date

Revised 10/1/2013

COMANCHE INDEPENDENT SCHOOL DISTRICT
CATASTROPHIC SICK LEAVE POOL
REQUEST FOR DAYS

Name: ______________________________ Date: ____________________

Position/Assignment: ____________________ School/Department ______________

Employed by Comanche ISD since __________________ (date)

Days absent current school year _______________

Reason For Requesting Sick Leave Pool Days:

I have used all of my available state and local sick leave days for this school year.

Number of days requested from the Pool: _____________

Pool sick leave days should begin: ______/_____/______ and end: ______/_____/______
Month Day Year *Month Day Year*

Do you anticipate any additional days to be needed for follow-up examinations or treatment?

Yes ________ No ________ If yes, please explain: ______________________

____

____

The above requested days are needed for the reason of personal illness or injury as described:

____

____

Date of catastrophic illness/injury:____________ Date physician consulted:______________

Name, address and phone number of treating physician:

____

____

____

A statement from my physician is attached: Yes ________ No ________

Did the condition require hospitalization? Yes ________ No ________

Name of hospital:____

Dates of hospitalization: Beginning: ________/_____/______ and Ending: _______/_____/______
Month Day Year Month Day Year

I certify that the information provided in this request is true and correct.

_______________________________________ _________________________________
Signature Date

FOR SCHOOL USE ONLY

Date Received:____

Date Leave Request Granted: ____________ ***OR*** Denied:____________________

Date Employee Notified:____

Revised 10/1/2013

COMANCHE INDEPENDENT SCHOOL DISTRICT
CATASTROPHIC SICK LEAVE POOL
AUTHORIZATION FOR USAGE

Applicant: ______________________________ Employee ID No: _______________

Sick Leave History

Days brought forward __________

Days earned this year __________

Days used this year __________

Number of days requested from Pool __________

Committee Action

Granted ___________ Denied _____________

Number of days approved ________________________

Chairperson ________________________________ Date _______________________

Vice-Chairperson or Secretary ____________________________

cc: Applicant Personnel File
Business Office
Committee File
Applicant

Revised 10/1/2013