SHOSHONE COUNTY SICK LEAVE BANK REQUEST

Please attach completed Parts I and II to this request form and return it to the Sick Leave Bank Chairperson no later than the 15th of the month to be considered for that month's payroll. Any incomplete or late forms will not be considered until the following month. All claims must be filed within sixty (60) days of the initial date of the application's illness or injury.

TO BE COMPLETED BY EMPLOYEE

I request that the Sick Leave Bank Committee approve _____days from the SLB to be credited to me for my illness/injury for the following dates:

From:_____

To:_____

I understand that a completed physician's form and employee form must be attached before any action can be taken.

Comments:_____
_____
_____

Are you receiving any other assistance or compensation for this claim/condition? (FMLA, Workman's Comp, Supplemental Insurance, etc.)

_____Yes _____No

If yes, from what source?_____

TO BE COMPLETED BY SLB CHAIRPERSON

( ) DAYS APPROVED x .5 =
_____ DEDUCTION

( ) DISAPPROVED BY COMMITTEE

( ) FURTHER INFO NEEDED

COMMENTS:_____
_____
_____
_____

_____
chairperson signature

Date:_____

TO BE COMPLETED BY SUPERVISOR

Last Day Worked: _____

Sick Leave Hours Used:_____
Balance Remaining:_____

Supervisor's Recommendation:_____
_____

Supervisor's Signature: _____

Date:_____

DISTRIBUTE TO:

original –Auditor's Office (employee file)
copies – Employee
--SLB Secretary
--Payroll

*revised 10/20/2017

SHOSHONE COUNTY SICK LEAVE BANK REQUEST—Part I

Attending Physician's Statement

Patient Name:_____

1. Diagnosis (including complications):

_____

_____

_____

2. Is the Condition:
   ___Result of Sickness; Date of first symptoms:_____
   ___Due to an Accident; Date of Accident:_____
   ___Employment Related; Date of Incident:_____
   ___Due to Pregnancy; Approximate date pregnancy commenced:_____

3. Date patient first consulted you for this condition:_____
   Does this condition prevent employee from working? _____
   If yes, patient will be unable to work from _____ to _____

4. List the names and addresses of other treating physicians:
   _____
   _____
   _____

5. Has the patient ever had the same or similar condition? _____
   If yes, please give dates and describe:_____

_____

_____

6. All dates of service (if supplemental report, you need only show the dates since the last report):
   Office:_____
   _____
   Hospital:_____
   _____

7. Is the patient still under your care for this condition?_____Yes_____No
   If **NO**, the date released to return to work:_____
   If **YES**, approximate date to return to work:_____

Physician's Name:_____

Signature:_____ Date:_____

Address:_____Phone:_____

*revised 10/20/2017

SHOSHONE COUNTY SICK LEAVE BANK REQUEST—Part II

Employee Statement

1. Name of Employee:_____

2. Department:_____

3. Supervisor:_____

4. Date of Birth: ____/____/_____ Sex: ( ) Male ( ) Female

5. Address:_____

6. Phone: Home/Cell_____ Work_____

7. Date of illness or injury:_____

8. Date you were first treated for your illness or injury:_____

9. Last day worked:_____

10. Normal work week: Total days worked per/wk_____Total hours worked per/wk_____

11. Have you returned to work? If yes, when?_____
If no, when expected?_____

12. If you were hospitalized, answer the following:
a. Name and address of hospital:_____
b. Date admitted:_____at_____hour ( ) am ( ) pm
c. Date discharged:_____at_____hour ( ) am ( ) pm

13. Describe injury or illness: _____

14. Have you had the same or similar condition in the past?_____
If yes, treated by: _____

15. If injury was due to an accident, where and how did it occur?

_____

_____

16. Was the injury or sickness caused or aggravated by your work?_____If yes, please explain:_____

_____

The above statements are true and complete to the best of my knowledge. The information provided is to be used solely for the administration of claims. A true copy of the authorization is available to the patient or his/her authorized representative at any time, upon request.

Date:_____Signed:_____

*revised 10/20/2017