City of Brockton
BROCKTON PUBLIC SCHOOLS
Michael P. Thomas • Superintendent of Schools

Kathleen Moran, *Executive Director*
Office of Human Resources
Phone (508) 580-7535 Fax (508) 580-7091
kathleenmoran@bpsma.org

_____
Name

_____
Address

_____
City, state, zip code

Sick Leave Bank Committee
C/O Kathleen Moran
Human Resource Office
43 Crescent Street
Brockton, MA 02301

To the Sick Bank Committee:

I am a member of the sick leave bank. My accumulated sick leave will be used as of _____.

Please consider this letter as an application to the Sick Leave Bank. At this time, I am requesting _____days to be used during my disability.

*** The Brockton Public Schools BEA Sick Leave Bank form is attached. (Must be signed by attending health care provider.)

Thank you for your consideration.

Sincerely,

_____ (Signature)

_____ (Please Print)

11/4/15 mjp

BROCKTON PUBLIC SCHOOLS
BEA SICK LEAVE BANK FORM

NAME_____**PHONE**_____

POSITION_____**SCHOOL**_____

THE FORM SHOULD BE COMPLETED BY THE ATTENDING PHYSICIAN AT THE BEGINNING OF THE DISABILITY AND RETURNED TO THE HUMAN RESOURCES OFFICE. (43 Crescent St., Brockton, MA 02301 or fax 508-580-7091)

I, _____do hereby certify as follows:
Print Name of Attending Physician

PART A: MEDICAL FACTS

1. Approximate date condition commenced:_____

Probable duration of condition:_____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No___ Yes___

If so, dates of admission:_____

Date(s) you treated the patient for condition:_____

Will the patient need to have treatment visits at least twice per year due to the condition?

No___ Yes___

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No___ Yes___

If so, state the nature of such treatments and expected duration of treatment:_____

_____

2. Is the medical condition pregnancy?

No___ Yes___

If so, expected delivery date:_____

3. Answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?

No___ Yes___

If so, identify the job functions the employee is unable to perform:_____

_____

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

No___ Yes___

If so, estimate the beginning and ending dates for the period of incapacity: _____

_____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?

No___ Yes___

If so, are the treatments or the reduced number of hours of work medically necessary?

No___ Yes___

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

Estimate the part-time or reduced work schedule the employee needs, if any:_____

_____

_____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

No___ Yes___

Is it medically necessary for the employee to be absent from work during the flare-ups?

No___ Yes___

If so, explain:_____

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency:_____times per_____week(s)_____month(s)

Duration:_____hours or_____day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Provider's Name and Business Address:_____
Print Name

_____
Street City State Zip Code

Type of practice:_____

Medical specialty:_____

Telephone:_____ Facsimile:_____

_____
Signature of Health Care Provider **Date**