Fort Worth Independent School District
Sick Leave Program (SLP)
Sick Leave Days Request Form
(Must be filled out completely)

First Name: _____M.I._____ Last Name: _____

Date of Birth: _____ Sex: ❑Male ❑Female Social Security # (last 4 digits): _____

Employee ID #: _____

Address: _____City/State/Zip: _____

Home Phone:_____❑Okay to leave message Cell Phone: _____❑Okay to leave message

Email:_____

Job Title**:** _____ Number of Contract Days: _____

Work Location Name/Number #: _____Work Location Phone Number: _____

Years of Service with Fort Worth ISD: _____

1. Have you requested days from the Sick Leave Bank (SLB)? Yes No
2. How many requests have you submitted to the SLB? _____
3. Was your request approved? Yes No
4. If no, explain why? _____
5. If yes, indicate the last date SLB days were granted: _____
6. How many SLB days were granted: _____
7. Have you exhausted all paid leave? Yes No If no, **STOP!** You must exhaust all paid leave.
8. Provide the last day you worked before absences due to medical condition began: _____
9. I request days from the SLP (number of days requested) must be in increments not to exceed twenty-five (25) for catastrophic illness or family member's terminal illness and ten (10) days for lesser illness extended by complications with hospital admittance).
10. Date any days granted are to begin:
11. First day absent with this illness or accident:

By signing, I hereby confirm all answers provided are true, accurate and complete. I also authorize investigation of all statements contained in this application. I understand that the falsification, misrepresentation or omission of fact on this application (or any other accompanying documents) may be cause for denial of days from the Sick Leave Program.

Signature: _____ Date: _____

This request cannot be acted upon nor marked received until the Physician's Statement is received by Health Services Dept. Note: Any person requesting days gives permission for the Health Services Dept. to talk with their doctor and/or office staff concerning their illness or accident and also gives permission for their doctor and/or office staff to release information to the Health Services Department. This form must be completely filled out and submitted to FWISD's Health Services Dept., Attn: SLP Executive Committee, 7060 Camp Bowie Blvd., Fort Worth TX 76116 or cassandra.miles@fwisd.org.

Fort Worth INDEPENDENT SCHOOL DISTRICT | DIVISION OF TALENT MANAGEMENT

Fort Worth ISD Sick Leave Program
Physician's Statement Form
(Must be filled out completely)

Patient Information

Name: _____ Birth Date: _____ Sex: M F

(First) (MI) (Last)

Social Security # (last four digits): _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Note: Any person requesting days gives permission for the Health Services Department to talk with their doctor and/or office staff concerning their illness or accident and also gives permission for their doctor and/or office staff to release information to the Health Services Department.

Diagnosis or nature of illness or Injury (Lay Language):_____

_____

Date of Consultation: _____

Dates Hospitalized: _____ Discharged: _____

Admitted: _____

Prognosis: _____

Is this illness Catastrophic or Life-Threatening? _____

Date Patient will return to work (if known): _____

Total Disability: From: _____ Through: _____

Comments or Restrictions: _____

Physician's Information

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

_____ _____

Signature of Examining Physician Date

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