Sick Leave Bank Request

This packet contains the forms necessary to apply for Sick Leave Bank benefits under the OPTA 2018-2022 Collective Bargaining Agreement. The Sick Leave Bank Committee requests, that whenever possible, documentation is submitted for review prior to running out of allocated Sick/Personal Leave. All paperwork must be completed in its entirety in order to avoid denial or postponement of request.

Eligibility

To be eligible for days from the Sick Leave Bank all of the following conditions must be met:

1) The teacher must exhaust all of their accumulated sick leave,
2) The teacher, or immediate family member as defined in Section 24-6 of the Illinois School Code, must incur or experience an acute, catastrophic, or prolonged illness or injury that is considered life-threatening or could result in a serious residual disability, and
3) The teacher must submit certification from a physician of theirs, or if the request is for the care of an immediate family member; certification from their immediate family member's treating physician. Such certification must be submitted on the enclosed Sick Leave Bank Request Form.

Elective surgery or procedures do not qualify as a personal illness for purposes of drawing from the sick leave bank. An elective surgery is one that is not deemed medically necessary and/or can be reasonably delayed until a break in the teacher's work responsibilities (i.e. winter break, spring break, or summer break) without detriment to their health.

How to Apply

1. Employee must meet with Human Resources to determine if they qualify for an FMLA and if they do, submit the proper paperwork. Qualifying for FMLA does not guarantee a grant of days from the Sick Leave Bank.
2. Employee must complete the Sick Leave Bank Request Form
   a. Please E-mail (OPTASLB@opta97.com) your form directly to the SLB
3. Treating Physician must complete a Sick Leave Bank Physician Form
   a. Make sure to fill in the top portion of the form before giving the paperwork to the treating physician to complete
   b. The Physician's office E-mail (OPTASLB@opta97.com) your form directly to the SLB

Review of Your Request

1. Once the Sick Leave Bank committee has received all documents, the committee will review the request. Confirmation of receipt will be sent via e-mail.
2. Please allow the committee 10 work days to process your request, following the receipt of necessary documentation.
3. The committee will notify you through your **personal** e-mail about their decision.

Questions?

If you have questions about filing for Sick Leave Bank benefits, please e-mail your Sick Leave Bank Committee at OPTASLB@opta97.com

OPTA SICK LEAVE BANK REQUEST FORM

(Please complete this form in its entirety in order to avoid denial or postponement of request.)

Employee Information

Name:	Personal e-mail:
Work Location:	Cell Phone:

Circle one:

Is this request a work-related illness/sickness?	***Yes***	***No***
If yes, did you file for workers compensation?	***Yes***	***No***
Are you receiving workers compensation or disability?	***Yes***	***No***

Request Information

Reason for Sick Leave Bank Request: *Do not include any genetic information*	
Patient is: ☐ Employee or ☐ Immediate Family Member* : ______________________(relation) * Per Illinois School Code Immediate Family Members include parents, spouse, brothers, sisters, children, grandparents, grandchildren, parents-in-law, brothers-in-law, sisters-in-law, and legal guardians.	
Current number of days in AESOP: Sick: Personal:	Return-to-work date:
Number of days requested:	Anticipated dates for follow-up examinations:

Attending Physician Information

Physician's Name:	
Physician's Address:	
Physician's Phone Number:	Physician's Fax Number:

I certify that the information provided in this application is correct to the best of my knowledge.

______________________________________ ______________________

Signature of Employee or Legal Representative **Date**

Employee must return this completed form directly to the OPTA Sick Leave Bank Committee
E-mail: OPTASLB@opta97.com

OPTA SICK LEAVE BANK PHYSICIAN FORM

To be emailed directly to the Sick Leave Bank by treating Physician

Employee Information and Authorization to release information

Name:	Patient: *(Self or name of immediate Family Member)*
I hereby authorize the designated physician to release to the OPTA Sick Leave Bank pertinent information from the above patient's medical file related to this request: Signature of Patient or Legal Representative: ________________________________ Date: ___________	

Physician Statement:

MEMO TO THE PHYSICIAN: *The above employee is requesting a grant of paid days through donations to the Sick Leave Bank by fellow employees.* ***To qualify, the employee or immediate family member, must incur or experience an acute, catastrophic, or prolonged illness or injury that is considered life-threatening or could result in a serious residual disability.*** *Surgery/Procedures that are not deemed medically necessary and/or can be delayed until a break in the teacher's work responsibilities (i.e. winter break, spring break, or summer break) without detriment to their health does not qualify as illness for purposes of drawing from the bank. Please provide, in terms that will be understood by the committee, a complete statement of medical diagnosis (****no genetic information may be provided****), treatments, & prognosis:*

Leave Type: *Check one of the below and answer corresponding questions*

☐ Consecutive: ___________ to _____________
Beginning Date/Estimated Ending

Patient Return to Work Date: _____________

Anticipated # of follow up appointments: ________

☐ Intermittent: ____________________________
Estimated # of days needed for qualifying illness

Is employee able to work now? YES NO

Scheduled appointment dates: ______________
____

For all Surgeries:

Could the recommended surgery be scheduled during an extended school break (ie: summer or winter) without being detrimental to the patient's health and/or result in a serious residual disability?

YES NO

I certify that the patient is experiencing an acute, catastrophic, or prolonged illness or injury that is considered life threatening and/or could result in a serious residual disability.

Attending Physician's Signature ____________________ Date ____________________

Attending Physician's Name ____________________ Attending Physician's Phone Number ____________________

Physician must return this completed form directly to the OPTA Sick Leave Bank Committee
E-mail: OPTASLB@opta97.com