THE CLASSICAL ACADEMY
EXTREME ILLNESS OF A FAMILY MEMBER
LIMITED SICK LEAVE BANK APPLICATION FORM

Full Name of Staff Member: _____

Address: _____ Home Phone: _____

Position/Title: _____ Location: _____

Employment Status: ☐ Full time ☐ Part time: Days/# of hours per week: _____

Principal/Supervisor: _____

Are you currently a member of TCA's Limited Sick Leave Bank? ☐ Yes ☐ No

Family member's name: _____

Relationship of ill or injured family member to staff member: _____

Staff member's staff leave balance: _____ Paid vacation balance: _____

Date all staff leave and paid vacation will be exhausted: _____

Have you previously received an award of days from the Limited Sick Leave Bank?
☐ Yes ☐ No

Number of Limited Sick Leave Bank Days requested (Maximum of 20 days): _____

I certify the above information is true to the best of my knowledge and belief.

Staff Member's Signature: _____ Date: _____

IMPORTANT NOTES:

- The staff member must submit a Leave Request in IVisions
- The staff member must submit a Health Care Provider's Statement certifying that the staff member's presence is required to care for a critically ill family member.
- Letter to Executive Director requesting days.
- The staff member must have exhausted his/her staff/personal leave and paid vacation before receiving any Limited Sick Leave Bank days.
- Awards of Limited Sick Leave Bank days shall be made In increments no greater than 20 days, at 70% of the staff member's pay, and may not exceed a total of 60 days during the lifetime of an staff member's employment with The Classical Academy.

The Classical Academy Leave Request
Health Care Provider's Statement Form
(Need to Care for Family Member)

Employee: _____ Date: _____

Family Member/Patient: _____

Health Care Provider: _____

Health Care Provider Phone Number: _____

The above individual, who is *an employee of The Classical Academy, has informed us that his/her presence* is *required to care for a seriously ill family member. We have requested that this individual provide us with medical documentation substantiating the necessity of his/her presence to care for a seriously ill family member. Please complete the following for our Human Resources files and return by fax to 719-488-6333.*

I. Please indicate whether it is your opinion that the individual name above as the employee is needed to care for the seriously ill family member who is your patient.

_____

_____

_____

_____

2. Is the patient's injury/illness of a life threatening nature? ____ Yes ____No

3. If a leave of absence is recommended for the employee to care for the family member, what is the anticipated duration of the leave *(start date of leave and projected end date)?*

_____

_____

Health Care Provider Signature: _____ Date: _____