Point Isabel Independent School District

SICK LEAVE BANK HANDBOOK

Dr. Lisa Garcia, Superintendent

Point Isabel Independent School District does not discriminate on the basis of race, color, national origin, age, religion, sex, disability, or any other legally protected status in employment or provision of services, programs, or activities.

El distrito escolar de Point Isabel no discrimina en base a raza, color, origen de nacionalidad, edad, religión, sexo, discapacidad, o cualquier otro estado legalmente protegido en el empleo o en la prestación de servicios, programas o actividades.

SICK LEAVE BANK HANDBOOK

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Point Isabel Independent School District

Guidelines for Administration of Sick Leave Bank

SECTION I

Purpose

The purpose of the Sick Leave Bank (SLB) is to provide additional paid sick leave days to members of the bank in the event of a *catastrophic illness or injury which render the member unable to perform the duties of his or her position and causes a substantial loss of income.

> ***Catastrophic Illness- The patient's illness, injury, or condition is life threatening or requires in-patient hospitalization or is expected to result in disability or death resulting into (10) ten or more absences.***

SECTION II

Eligibility

All Point Isabel Independent School District, full-time, regular employees whose work calendar is ten, eleven or twelve months shall be eligible for SLB membership. (This includes employees who works twenty (20) hours or more per week in a full-time position.)

Procedures for Joining

- Any eligible employee may join the Sick Leave Bank (SLB) by contributing three (3) days of available local sick leave.
- The enrollment period will be August 1st through September 30th of each school year.
- Employees desiring to join the SLB must complete the membership application form and submit it to the Human Services Office for verification of employment eligibility and approval for processing by payroll.

SECTION III

Regulations on Contribution of Days

- An employee must contribute three (3) days of available local sick leave. These three days will be subtracted from the employee's local sick leave record.
- The three days donated by each employee becomes the property of Point Isabel ISD Sick Leave Bank. No donations will be returned.
- For the purposes of the Sick Leave Bank, the calendar year will be September 1st through August 31st. Members who use days from the SLB during the SLB calendar year, will be required to donate an additional three (3) days of anticipated earned sick leave days the following school year in order to have continuing membership in the SLB.

Cancellation of Membership

If a member cancels membership in the SLB, he/she will forfeit utilization of SLB and the three donated days will remain the property of P I I S D's Sick Leave Bank. If an employee chooses to regain membership, the employee may do so by donating three (3) days during the enrollment period.

SECTION IV

Granting Days from Sick Leave Bank

- Sick leave days from the bank are available only in the event of *catastrophic illness/ injury which will render the member unable to perform the duties of his/her position.
- A member or family designee may request days from the Sick Leave Bank only after member has exhausted all available state leave, local leave, vacation days or any other accumulated compensation days; and after being sick 5 consecutive days.
- SLB days will be granted for absences from working days only.
- The maximum number of SLB days that may be granted to a member during the September 1st through August 31st year will be thirty (30) days. Minimum request is ten (10) days.
- If a member that has been granted less than thirty (30) SLB days returns to work and has the same or a different catastrophic illness or injury, the member may apply for SLB additional days which under no circumstances can exceed the thirty (30) SLB days per year.
- A member shall be reimbursed for the amount actually docked. Reimbursement will be made ONLY in the member's regular payroll check after the SLB Committee has approved the requested days.
- Sick leave days will not be granted when a member is receiving monies from the Workers' Compensation Act.
- Unused sick leave bank days at the end of August 31st shall be carried over to the next SLB year September 1st through August 31st.
- Loss of Right to Utilize Sick Leave Bank Days
  A member will lose the right to utilize SLB days by: 1) separation of employment with the Point Isabel ISD, 2) suspension from employment at Point Isabel ISD, 3) choosing not to donate (pay back) the required days after utilizing the SLB.

SECTION V

Requesting Sick Leave Bank Days
A SLB member must request use of Sick Leave Bank Days by completing the request form and attending physician's statement form provided by the district. In the event that the member is incapacitated, a family member or designee may make the request

Submittal of Attending Physician's Statement
As part of the request for SLB days, the member must submit the attending physician's statement on the official Sick Leave Bank Physician Statement form provided by the PIISD.

Appropriate Forms
REQUEST FOR DAYS FROM SICK LEAVE BANK form and the SICK LEAVE BANK PHYSICIAN'S STATEMENT form are available from the campus or department administrator or Human Resources office. The application must be completed in its entirety to be considered by the SLB Committee.

Refusal of Request
The SLB Committee will refuse to consider a request that is not on forms provided by the district and that does not contain ALL the required information.

SECTION VI

The superintendent or designee shall develop regulations for the operation of the sick leave bank that address the committee or administration authorized to consider requests for leave from the sick leave bank and criteria for granting requests and other procedures deemed necessary for the operation of the sick leave bank.

SECTION VII

Procedures for Questions Not Addressed in the Sick Leave Bank Handbook Any questions concerning membership, regulations, applications, or pertinent to the Sick leave Bank that may arise because they are not specifically covered in the Sick Leave Bank Handbook, shall be submitted to the SLB Committee who will make a recommendation to the Superintendent of schools for a final decision.

Forms/Additional Information

Point Isabel Independent School District

MEMBERSHIP APPLICATION FOR SICK LEAVE BANK

(TO BE COMPLETED BY PIISD EMPLOYEES
NOT CURRENTLY MEMBERS OF THE SICK LEAVE BANK)

Employee's Name:____
(Type or Print FULL Name) Employee

ID #:_________________________

Campus/Department: ________________ Position: ___________________

I have read the guidelines for the administration of the Sick Leave Bank for Point Isabel Independent School District and agree to abide by them.

INTERESTED IN PARTICIPATION:

_____ I wish to participate in the Sick Leave Bank by donating three (3) days of my **available** leave. I understand that all donations to the Sick Leave Bank become the property of the Bank.

___________________________________ __________________________
Signature of Employee Date

PLEASE RETURN COMPLETED APPLICATION TO YOUR IMMEDIATE SUPERVISOR WHO WILL FORWARD IT TO THE EMPLOYEE BENEFITS OFFICE.

(PLEASE KEEP A COPY *FOR YOUR PERSONAL FILE)*

REQUEST FOR SICK LEAVE BANK DAYS

Please complete this form and return to Employee Benefits at the Point Isabel I.S.D. Administration Building. An official **Sick Leave Bank Attending Physician's Statement** must also be submitted before this request can be considered. Sick Leave Bank days shall be used only for the catastrophic illness or injury of the employee. Please refer to District policy DEC for more information.

Date:______/_____/______

Employee Name:____Employee ID #_____________________

Address: ____

Telephone:___________________Campus/Dept.________________Position:_________________________________

I am requesting leave: Begin:______/_____/______ End:______/_____/_______

Number of Sick Leave Bank Days requesting: __________________

Nature of illness or injury*: ____

____

____

Date illness began or accident occurred: _____/_____/_____

Name, address, and phone number of attending physician: ____

____

I certify that the information given on this request for sick leave bank days is accurate and true. I am a Sick Leave bank member. I am experiencing a catastrophic illness/injury and I am unable to return to work due to this condition. I have or will have used all my available state and local leave, as well as any compensatory time and vacation days, as applicable.

Signature of Employee:____Date: _________________________

If you are not the employee indicate your relationship to the employee:_______________________________________

* ***GINA NONDISCLOSURE NOTICE:*** *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

SICK LEAVE BANK COMMITTEE DECISION:

________Approved Sick Leave Bank Days for___________days.

________NOT Approved Reason:____

_______Other

Signature: ____ _____________

(Committee Chairperson) *Date*

Signature for Processing ONLY: ____ _____________

(Executive Officer) *Date*

Sick Leave Bank Attending Physician's Statement

EMPLOYEE INFORMATION (*to be completed by the employee*)

Employee (Patient) Name:____Employee PIISD ID #_______________________

Campus/Dept.:____Date: _________________________________

****

MEDICAL CERTIFICATION ***(to be completed by the attending physician)***

Please complete the following information regarding the patient named above.

Name of Attending Physician:____

Address:____

Describe illness or injury in lay terms: ____

____

____

Date of diagnosis: _____/_____/_____

Check all that apply:

The patient's illness, injury, or condition: ❒ is life threatening, ❒ requires in-patient hospitalization, and/or ❒is expected to result in disability or death.

Explain the short-term prognosis: ____

____

Explain the long-term prognosis: ____

____

Dates of treatment: _____/_____/_____ End: _____/_____/_____

Is patient still under your care? ❒ Yes ❒ No

When can the patient be expected to return to work: ____

Can the patient return to work in any capacity? Please specify: (i.e. light duty) _____________________________

____

Hospitalization:

Name and address of hospital: ____

____

Date admitted: _____/_____/_____ Date discharged: _____/_____/_____

I certify that the information given on this Attending Physician's Statement is accurate and true.

Physician's Signature:____ Date: _______________________________

Please do not use a rubber stamp for signature

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