



ADMINISTRATORS' SICK LEAVE BANK APPLICATION

- Eligible conditions must meet the definition of catastrophic illness or injury presented in the Administrators' Sick Leave Bank (ASLB) Guidelines.
- Upon application approval, benefits are subject to a ten (10) day deductible/waiting period. If you are unable to meet the deductible through your own accumulated sick/personal/annual leave time, a payroll docking/unpaid leave at the beginning of your benefit period will occur.

Name: _____ Employee Number: _____

Mailing Address: _____ Zip Code: _____

Phone #'s: Home: _____ Cell: _____ Work: _____

Work Location Number: _____ Location Name: _____

Site Supervisor: _____ Site Secretary: _____

Last Day Worked: _____ Beginning Date: _____ Ending Date: _____

Physician's Name: _____ Physician's Phone: _____

- Attach a Administrators' Sick Leave Bank 'Physician's Statement' completed and signed by your licensed, certified physician
- Alteration or falsification of information on either this Application or the Physician's Statement could result in termination of benefits and disenrollment from the Administrators' Sick Leave Bank.

Nature of Illness: _____

Is this work related? Yes No Is this condition the result of an accident at work? Yes No

Is surgery required? Yes No Surgical procedure required: _____

List medications prescribed for this condition: _____

Date of onset of current illness: _____

Have you had this illness previously? Yes No If yes, when? _____

Have you requested ASLB benefits for this condition previously? Yes No If yes, when? _____

Have you received ASLB benefits previously for an unrelated condition? Yes No If yes, when? _____

I agree to abide by the terms of the guidelines that provide for the recovery of benefits paid by other insurance or liability coverage. In the event of an insurance settlement, I understand that I am responsible for repayment in full to the ASLB of benefits paid to me as the result of an accidental injury.

Applicant's Signature: _____ Date: _____

- Return the original Application and Physician's Statement to APS ASLB via email to Extended.Leaves@aps.edu (PREFERRED METHOD);
- OR deliver in-person to 6400 Uptown Blvd NE, Suite 115 East (this is **NOT** the APS mailing address);
- OR the Physician may fax it to (505) 889-4883. No third party faxes will be accepted.



ADMINISTRATORS' SICK LEAVE BANK
Physician's Statement

Patient's Name: _____

Patient's Address: _____

I authorize _____ (Physician's name) to release all records, including but not limited to medical and/or psychological records, related to this claim to the Albuquerque Public Schools Administrator's Sick Leave Bank and the APS Office of Employee Assistance.

Employee Signature: _____ Date: _____

MEMO TO PHYSICIAN: Compensation benefits from the Administrators' Sick Leave Bank (ASLB) are available to ASLB members who have exhausted all accumulated leave and are experiencing a serious/catastrophic illness or injury. Please provide the ASLB all of the information requested. An incomplete statement will delay processing of the employee's application and may cause a salary docking from the next paycheck if the employee has exhausted all available leave. Thank you.

DIAGNOSIS AND NATURE OF ILLNESS: _____

PROGNOSIS: _____

Have you treated the patient previously for this condition? Yes _____ No _____

Please provide detailed information on TREATMENT PLAN: _____

PRESCRIBED MEDICATION: _____

Beginning and estimated ending date for the period of incapacity: _____ / _____
Beginning Ending

Is patient able to work now? _____ DATE PATIENT CAN RETURN TO WORK _____
A specific date is necessary or the application will not be processed.

Will patient require intermittent leave for follow-up care after the initial leave? Yes _____ No _____

Please explain why treatment cannot be postponed to a non-work period: _____

Physician's Signature Date
Please circle one: Physician Psychiatrist Licensed Clinical Psychologist

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