ALBUQUERQUE PUBLIC SCHOOLS – ALBUQUERQUE TEACHERS FEDERATION – ALBUQUERQUE FEDERATION OF CLASSIFIED PROFESSIONALS

SICK LEAVE BANK APPLICATION

(Page 1 to be completed by Employee; Page 2 to be completed by Physician.)

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

Name:_____ Employee Number:_____

Mailing Address:_____ Zip Code:_____

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

APS Email Address:_____ Personal Email Address:_____

Work Location Number:_____ Location Name:_____

Site Supervisor:_____ Site Secretary:_____

Last Day Worked:_____ Leave Start Date:_____ Anticipated Leave End Date:_____

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

- Attach a 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 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:_____

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

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

Have you received SLB 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 Sick Leave Bank of benefits paid to me as the result of an accidental injury.

Applicant's Signature:_____ Date:_____

Please email the completed Application and Physician's Statement to:

- **APS Sick Leave Bank at Extended.Leaves@aps.edu.**
- **The Physician may fax it to (505) 884-0536 OR email to Extended.Leaves@aps.edu.**

revised July 2024

ALBUQUERQUE PUBLIC SCHOOLS
SICK LEAVE BANK
Physician's Statement

Patient's Name:_____

Patient's Address:_____

I authorize_____ to release all records, including but not limited to medical and/or psychological records, related to this claim to the Albuquerque Public Schools Sick Leave Bank.
(Physician's name)

Employee Signature:_____ Date:_____

MEMO TO PHYSICIAN:
Compensation benefits from the Sick Leave Bank are available to SLB members who have exhausted all accumulated leave and are experiencing a serious/catastrophic illness or injury. Please provide the Sick Leave Bank 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_____
An anticipated date is required, 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

Please email the completed Application and Physician's Statement to:

- **APS Sick Leave Bank at Extended.Leaves@aps.edu.**
- **The Physician may fax it to (505) 884-0536 OR email to Extended.Leaves@aps.edu.**