

TABCO SICK LEAVE BANK CLAIM FORM

FAXED OR PHOTOCOPIED FORMS WILL NOT BE ACCEPTED.
COMPLETED CLAIM FORM MUST BE RECEIVED IN TABCO OFFICE BY ____/____/____
TO BE CONSIDERED BY THE SICK LEAVE BANK COMMITTEE AT ITS NEXT MEETING.

FOR COMMITTEE USE ONLY
CLAIM NO: _____
LAST DATE COVERED BY EARNED SICK LEAVE: _____

PLEASE TYPE OR PRINT IN INK

Mr / Mrs / Miss _____ TABCO Member ___ Yes ___ No
Last First Middle / Maiden
Home Address _____ Date of Birth ____/____/____
Number/Street City State Zip Code
Social Security # _____ - _____ - _____ Home Phone () _____ Yrs. employed by BCPS _____
Work-Site _____ Position _____ Was this illness/accident work-related? ___ Yes ___ No
First day out of work ____/____/____ Have you used Sick Leave Bank Benefits before? ___ Yes ___ No Year? _____
CIRCLE employment status: Full-time: 10 month / 12 month Part-time: Number of days per week _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the undersigned physician to release any information acquired in the course of my treatment or examination to the TABCO Sick Leave Bank Approval Committee. I understand that information contained on this form and any additional information received may be shared with the Risk Manager for Baltimore County Public Schools. Any days not used for the specific disability indicated on this form will be returned to the Sick Leave Bank.

SIGNATURE OF SICK LEAVE BANK MEMBER _____

FOR PHYSICIAN'S USE ONLY (ILLEGIBLE & INCOMPLETE FORMS WILL NOT BE CONSIDERED)

Patient is/was under my care and unable to work from ____/____/____ to ____/____/____

ICD9/DSM-IV CODE(S) _____

Diagnosis and impact on essential functions of the job: _____

SPECIFIC Plan of Treatment - including surgery, medications, therapies, or counseling _____

Upon returning to work, do you anticipate employee will need work restriction or accommodations? ___ Yes ___ No If yes, explain what restrictions/accommodations will be needed. _____

Date of Surgery (if applicable) ____/____/____ Date of Hospitalization (if applicable) ____/____/____ Prognosis _____

For Pregnancy - Expected Delivery Date _____ (claimant must notify TABCO of actual delivery date)

EMPLOYEE'S ANTICIPATED RETURN TO WORK DATE ____/____/____

Physician's Name (Please type or print) _____ Phone () _____ - _____

Address _____
Number/Street City State Zip

Board Certification Specialty _____ Physician's License # _____ State _____

PHYSICIAN'S SIGNATURE _____ Date ____/____/____

FOR COMMITTEE USE ONLY

Approved: ___ Yes ___ No Number of Days Approved: _____ Beginning ____/____/____ Ending ____/____/____

SLB REPRESENTATIVE SIGNATURE _____ Date ____/____/____ Comments: _____

Office of Risk Management _____ Date ____/____/____ IME Requested IME Scheduled

Distribution of forms: BCPS Risk Management, TABCO and employee

DATE FORM SENT TO EMPLOYEE _____

DATE RECEIVED FROM EMPLOYEE _____