GREATER LOWELL TEACHERS ORGANIZATION
SICK LEAVE BANK MEMBER APPLICATION FORM

Members Name: _____ Home Telephone _____

Home Address: _____

Attending Physician: _____Office Telephone _____

Address: _____

Attending Specialist:_____Office Telephone:_____

Number of days requested:_____ **MAXIMUM IS 30 AT ONE TIME**

Member Signature: _____Date:_____

Action Taken - To be completed by Sick Leave Bank Board

Application approved:_____ Denied:_____

Days Allowed: _____ Reason for denial _____

(Maximum Days Allowed to Draw at a Time is THIRTY (30) days)
(MAXIMUM IS 180 DAYS)

Starting Date: _____ Estimated Ending Date: _____

Other: _____

_____

_____

GLTO Sick Leave Bank Committee Signatures

_____

_____

_____

_____

_____

Date: _____

GREATER LOWELL TEACHERS ORGANIZATION
MEMBER SICK LEAVE BANK
APPLICATION FOR BENEFITS
COMPLETED OF PHYSICIAN OR SPECIALIST

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician/health care practitioner to release any information acquired in the course of my examination or treatment for the purpose of the Greater Lowell Teachers Organization Sick Leave Bank.

_____
Member/Patient Signature Date

1. Member Name:_____
2. Approximate date condition commenced: _____
3. Probable duration of condition and diagnosis:
   _____
4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks sick leave benefits (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   _____
   _____
   _____

Please respond Yes or No to the following questions:

	Yes	No	
5.	_____	_____	If for surgery, is it elective, cosmetic and unrelated to an underlying serious medical condition, disability, or accident?
6.	_____	_____	Is leave due to routine pregnancy or childbirth care?

7. In your medical opinion with a reasonable degree of medical certainty, when do you anticipate this person may return to employment to perform the essential functions of his/her position?_____
   _____
8. What is the last date this individual was evaluated by you for his/her medical condition?
   _____
9. Is this individual currently incapacitated to resume his/her position? Yes☐ No☐

   Provider's name and business address (please print):
   _____
   _____

   Provider's signature:_____Date:_____

   Telephone: (_____)_____Fax:(_____)_____