Appendix B: Sick Bank Member Application Form

Greater Lowell Teacher's Organization Sick Leave Bank
Member Application Form

Applicant's Name: ____

Home Telephone _______________________________ Mobile Phone Number: ________________________
In order to respect your recovery time, would you prefer text notifications of the status of your application?
❑ YES ❑ NO

Home Address: ____

City: ____ State: ______________________ Zip: ________

<u>Physician's Information</u>
Primary Care Physician: ____

Specialty: _______________________________________ NPI #: _________________________________

Office Telephone: __________________________________ Office Fax or Email: ______________________

Name or Address of Practice: ____

Surgeon or Specialist:____

Specialty: _______________________________________ NPI #: _________________________________

Office Telephone: __________________________________ Office Fax or Email: ______________________

Name or Address of Practice: ____

<u>Request Information:</u>
Number of days requesting:____________________ (MAXIMUM IS 30 per request)

Are you currently receiving or applying for benefits from any other source, including but not limited to Worker's Compensation, paid FMLA, etc.? Answering "yes" does not automatically disqualify you from receiving benefits.
❑ YES ❑ NO
If yes, provide a brief description: ____

Will you be working in or outside of Greater Lowell Tech in any capacity during your recovery/illness/disability?
❑ YES ❑ NO

Have you redeemed any personal accrued sick time under Article VI, section B, of the GLTO Contract?
❑ YES ❑ NO

Please provide a brief description of the diagnosis or circumstances prompting application for benefits:

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____

Optional Narrative: The space below can be used to provide any supporting information or details that you would like the committee to consider. This could include, but is not limited to, complications, hospitalizations, or other relevant details not yet presented.

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I attest to the accuracy of the information provided in the above narrative.

OPTIONAL-- Physician's Signature: ____ Date: ______________

I hereby certify that all of the information provided by me in this application (and any other accompanying documents) is correct, accurate and complete to the best of my knowledge, and that the falsification, misrepresentation or omission of any facts will be cause for denial of benefits and immediate termination from eligibility in the GLTO Sick Bank.

Member Signature: ____

Printed Name: ____ Date:________________

Appendix C: Sick Bank Application Medical Evidence Form

Greater Lowell Teacher's Organization Sick Leave Bank
Medical Evidence Form

Applicant's Name (Printed): ____

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

This form must be completed in its entirety by the attending physician or surgeon who is managing the health condition for which you are applying for Sick Leave Benefits. No part of this application can be completed by the member.

Diagnosis or condition: ____

Approximate date condition commenced: ____

Most recent date this individual was evaluated by you for this specific illness or condition? ____________________

Probable duration of condition: ____

Describe any medical fact related to the condition for which the applicant seeks Sick Leave Benefits (such as symptoms, diagnoses, treatment regimen, specialized equipment, etc).

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❑ YES ❑ NO Is this condition related to an elective or cosmetic procedure?

❑ YES ❑ NO Is this condition related to a serious medical condition, disability, accident or illness?

❑ YES ❑ NO Is this condition related to routine pregnancy or childbirth?

❑ YES ❑ NO Is this condition related to a Workman's Compensation Claim?

Is the applicant currently unable to perform the duties required to resume his/her position? ❑ YES ❑ NO

Physician's Name: ____ Phone: ___________________

Address: ____ Fax: ______________________

Physician's Signature: ____ Date: ____________________