APPLICATION TO USE SICK DAYS
FROM THE LONG BRANCH SCHOOL DISTRICT
SICK DAY BANK

Date of Application: _____

Name of Applicant: _____

Position of Employment: _____

Address: _____

_____

Phone Numbers: _____

_____

SECTION I.

APPLICANT'S ACKNOWLEDGMENT OF AND CONSENT FOR ACCESS TO USE OF PROTECTED HEALTH INFORMATION

To judge and corroborate your application's satisfaction of the criteria for the grant of sick days from the Sick Day Bank, the Long Branch Sick Day Bank Committee ("COMMITTEE") will likely need access to some or all of your medical health information ("MHI"). It is required by the Americans With Disabilities Act at 42 *U.S.C.* ' 12112(d) and 29 *C.F.R.* Parts 1630.13 and 1630.14 that any MHI collected be maintained as a separate confidential record and used only for certain purposes, such as an employee health program or to grant accommodations. As a consequence, the COMMITTEE requests the following permissions and information:

1. Consent/Authorization - I hereby give my consent and authorize the members of the COMMITTEE, who are representatives from the Board of Education of the City of Long Branch and, the Long Branch Administrators' Association, the Long Branch School Employees Association, and the Long Branch Federation of Teachers to access, use and discuss my MHI as described below, because I requested the use of sick days stored in the Sick Day Bank of the Board of Education of the City of Long Branch ("Sick Day Bank").

2. Effective Period - This authorization for release of my MHI covers the following period of time:

(a) from _____ to _____; OR

(b) all past, present and future time periods.

3. The Extent of Authorization

(a) I authorize the release by my medical advisors to the COMMITTEE of my MHI, including records relating to my mental health care and communicable diseases and HIV and/or AIDS and treatment of drug and/or alcohol abuse; OR

(b) I authorize the release by my medical advisors of my MHI with the exception of the following information:

_____Mental Health Records
_____Communicable Diseases, including HIV and AIDS
_____Alcohol/Drug Abuse Treatment
_____Other_____

4. Minimum Necessary Use by the Committee. My MHI may be used by the COMMITTEE, as I have authorized above, solely for purposes of deciding whether my request qualifies for use of sick days from the Sick Day Bank and for no other purpose. I understand that the COMMITTEE will take reasonable steps to limit the use and disclosure of my MHI to the minimum necessary to accomplish the COMMITTEE'S intended purpose. The COMMITTEE will file this application and my MHI in a filing system separate from my personnel file, which separate file shall be secured so as to maintain its confidentiality and protect it from any use other than as permitted herein.

5. Do you grant the COMMITTEE and its designated representative permission to contact your medical advisors, doctors and health care provides about your health condition relevant to your Sick Day Bank request?_____No _____Yes

6. Do you authorize your medical advisors, doctors and health care providers to speak with the COMMITTEE or its representative about your health condition relevant to your Sick Day Bank request?_____No_____Yes

7. Revocation of Consent/Authorization. I understand that I have the right to revoke this consent/authorization at any time, in writing, by communicating its revocation to the COMMITTEE c/o Dr. Jena Valdiviezo, Director of Personnel for Long Branch Public Schools 540 Broadway Long Branch, NJ 07740. I understand that my revocation shall not be effective to the extent that any person or entity has already acted in reliance on this consent/authorization.

8. I understand that my request for use of sick days from the Sick Day Bank is not conditioned on whether I sign this authorization.

Date: _____ _____

Signature (Employee)

SECTION II.
MEDICAL/HEALTH INFORMATION

1. Describe your health condition ("condition") which is the basis for your request to use sick days from the Sick Day Bank. (Your condition may not be related to work related injury.)

_____

_____

2. Approximate date your health condition commenced:_____

3. Probable duration of health condition:_____

4. Have you been admitted for a stay in a hospital, hospice, or residential medical care facility? _____No _____Yes. If so, where and when were your dates of admission?

_____

_____

5. Date(s) you were treated for the condition:_____

6. Will you need to have treatment for your condition? ____No ____Yes

7. Was medication, other than over-the-counter medication, prescribed?
_____ No _____Yes

8. Were you referred to other health care provider(s) for evaluation or treatment?
_____No _____Yes. If so, state the name of the health care providers, their contact information, the nature of such treatments and expected duration of such treatment:

_____

_____

9. Are you unable to perform any of his/her job functions due to the condition?
_____No _____Yes.

10. If so, identify the job functions which you are unable to perform and why:

_____

_____

11. Describe other relevant medical facts, if any, related to the condition for which you seek sick days (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

SECTION III.
NUMBER OF SICK DAYS NEEDED

1. How many sick days will you need? _____

2. Describe how you computed the number of sick days needed. _____

_____

3. Will you be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? _____ No _____Yes

If so, what is your medical advisor's estimate for the beginning and ending dates for the period of incapacity:_____

_____

4. Will you need to attend follow-up treatment appointments because of the medical condition? _____No _____Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

5. Estimate the duration of your related incapacity over the next six (6) months:

_____

_____

6. ANY ADDITIONAL INFORMATION WHICH YOU WOULD LIKE TO PROVIDE. _____

_____

_____

I certify to the truth and accuracy of the information which I have provided above.

Date:_____ _____

Employee

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