

**CATASTROPHIC SICK LEAVE APPROVAL FORM**

**WINSTON COUNTY BOARD OF EDUCATION**

**Double Springs, Alabama**

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**Section I: Employee Information**

Name of Employee \_\_\_\_\_

Home Address \_\_\_\_\_

Home Address \_\_\_\_\_

S. S. No. \_\_\_\_\_ Schl/Work Site Phone No. \_\_\_\_\_

Note: The employee must be a member of the Winston County School District SLB.

**Section II: Description of Illness/Injury**

Note: This section should be completed by the employee requesting to be granted approval for catastrophic sick leave.

A description of my illness/injury is as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

**Section III: Attending Physician's Statement (Required)**

Note: A statement from the attending physician attesting to the need for the employee requesting catastrophic leave to be placed on extended leave.

Name of Physician \_\_\_\_\_

Business Address \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone Number \_\_\_\_\_

Physician's Statement (may be attached or written) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Based on my professional opinion, I estimate that the person whose name is shown in Section I above will need to be away from his/her employment for \_\_\_\_\_ days, weeks (circle one).

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**Section IV: Board Action**

Recommended by Superintendent: Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Approved by Board: Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Directions: Complete and return this form to the Superintendent's Office.