

WINSTON COUNTY SCHOOLS
CATASTROPHIC ILLNESS
QUALIFICATION FORM

_____ SELF
_____ FAMILY MEMBER
(Specify Name & Relationship)

EMPLOYEE SECTION

Employee Name _____ SS# _____ School _____

Support Personnel _____

Certified Personnel _____ Position _____

TYPE OF ILLNESS _____

_____ DATE _____ EMPLOYEE'S SIGNATURE

PHYSICIAN STATEMENT

_____ DATE

DIAGNOSIS _____

Estimated length of time to be off work due to illness _____

_____ PHYSICIAN'S SIGNATURE

APPROVAL: Yes _____ No _____

_____ DATE

_____ SICK LEAVE BANK CHAIRPERSON

Copies: White
Pink
Yellow