SMYRNA SCHOOL DISTRICT
RDL – REQUEST FOR DONATED LEAVE

NOTE: THIS PAGE IS CONFIDENTIAL

PART I – To be completed by employee requesting donated leave

Name (Last, First, MI) Soc. Security # Date of Birth

Mailing Address (Street, City, State, Zip) Home Phone #

School/Building Date of Hire Work Phone #

Date of Accident or Beginning of Illness Date Became Disabled Date Return to Work

Briefly describe nature of illness/injury

Name of treating doctor Address Phone Treatment Date

Date Sick Leave exhausted Date ½ Annual Leave exhausted (if applicable)

Date all Annual Leave exhausted (if applicable)

Describe any other income you are receiving or are eligible to receive as a result of your disability. (e.g.. Social Security, Workers Compensation, disability Insurance, Pensions, etc.)

Upon presentation of the original or a photocopy of this signed authorization, I authorize my medical professional, hospital, medical institution, pharmacy, governmental agency, or my present employer having information concerning me, to release said information to the Smyrna School District or its designated representative to be used for determining my eligibility for Donated Leave. This authorization shall be valid from the date signed through the duration of this claim.

Employee's Signature Date

PART II – To be completed by payroll office

The above named employee has used or will use all accrued sick leave and at least ½ of his/her accrued annual leave (if applicable) as of _____ and has been employed by the District for 6 months or more. Further, the employee last worked on _____.

_____ _____

Authorized Signature Date

PART III – To be completed by the Donated Leave Review Committee

We have reviewed the donated leave request to determine if the employee meets all criteria for the Donated Leave Program.

We recommend _____ Denial _____ Approval granted through _____. For applicant to be eligible to receive donated leave beyond _____ applicant must submit another completed application including physician's certification of continued disability.

Based upon the days donated to the District Leave Bank for the applicant, we recommend that _____ be awarded _____ days of donated leave.

_____ _____

Committee Representative Date Committee Representative Date

PART IV – To be completed by the Superintendent or Designee

I have reviewed this application and the recommendation of the Donated Leave Review Committee and approve _____ disapprove _____ for the receipt and use of donated leave. Further, based on the recommendation of the committee, I am authorizing transfer of _____ days of donated leave to _____.

_____ _____

Superintendent or Designee Date

Smyrna School District - Request to Receive Donated Leave

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PART V – To be completed by the Employee's Physician

Name of Patient _____ Date of Birth _____

Present Address _____ SS# _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY
This patient is responsible for the completion of this form without expense to the Smyrna School District. Comprehensive medical information is required in order to evaluate the request for Donated Leave.

1. **HISTORY**

a) When did symptoms first appear or accident occur? _____

b) Date disability began _____

c) Has patient ever had the same or similar condition? _____
If "yes" please describe.

d) Is condition due to injury or sickness arising out of patient's employment? _____

2. **DIAGNOSIS (including any complications**

a) When did symptoms first appear or accident occur? _____

b) Diagnosis and ICD-9 or DSM-IV Code(including any complications)

c) Subjective symptoms

d) Objective findings (including current x-rays, EKG's, Laboratory Data and any clinical findings)

3. **TREATMENT DATES**

a) Date of First visit _____

b) Date of last visit _____

c) Frequency of visits Weekly _____ Monthly _____ Other _____

4. **NATURE OF TREATMENT (Including Surgery and Medications prescribed)**

Will treatment substantially improve function and employability? Yes ____ No ____

If yes, please specify.

5. **PROGRESS**

a) Has patient recovered _____ improved ____ unchanged _____ regressed _____

b) Is patient bed confined ____ hospitalized ____ ambulatory ____ house confined ____

c) Has patient been hospitalized? _____ If yes please provide name and address of hospital.

6. **CARDIAC (if applicable)**

a) Functional capacity Class I (no limitation) _____ Class II (slight limitation) _____
Class III (marked limitation) ____ Class IV (complete limitation) ___

b) Blood Pressure (last visit) Systolic _____ Diastolic _____

7. **LIMITATIONS**

Standing ____ Walking ____ Bending _____ Use of hands _____ sitting _____

Climbing _____ Stooping _____ Lifting _____ Psychological _____ Other _____

8. **PHYSICAL IMPARIMENT (As defined by Federal Dictionary of Occupational Titles)**

_____ Class 1 - no limitation of functional capacity; capable of heavy work. No restrictions (0-20%)

_____ Class 2 - medium manual activity (15-30%)

_____ Class 3 - slight limitation of functional capacity; capable of light work (35-55%)

_____ Class 4 - moderate limitation of functional capacity; capable of clerical (sedentary) activity. (60-70%)

_____ Class 5 – severe limitation of functional capacity; incapable of minimal sedentary activity. (75-100%)

Remarks:

10. **EXTENT OF DISABILITY**

	From Patient's Regular Occupation	From Any Occupation
a) Is patient now totally disabled?	Yes ___ No ___	Yes ___ No ___
b) If no, date able to work.	_____	_____
c) If yes, anticipated date patient will be able to resume any work	_____	_____

11. **REMARKS**

12. **RELEASE OF INFORMATION**

Has applicant provided authorization for release of medical information to the Personnel Office of the Smyrna School District? Yes ____ No ____

Date _____ Attending Physician Signature _____

Phone # _____ Address: _____

_____

_____