CAPISTRANO UNIFIED SCHOOL DISTRICT

San Juan Capistrano, California

"SICK LEAVE BANK REQUEST FOR WITHDRAWAL" FOR CATASTROPHIC ILLNESS/INJURY

EMPLOYEE ASSOCIATION: CSEA____ CUEA____ TEAMSTERS____ CUMA____

Name: _______________ _______________ ___________________________________
First Middle Last

Street Address: ____

City: ________________________________ State: _________________ Zip Code: ____________

Home Telephone: ____________________________ Work Telephone: _____________________

Job Title: ___________________________________ Site/Location: ________________________

Date of Birth: __________________________

Date of Onset of Illness/Injury: _________________ Last Date Worked: ___________________

Briefly Describe Nature of Illness/Injury: ____
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____

Number of Days Requested _____________ (not to exceed 90 days)

Physician's Name: ____

Physician's Telephone Number: _____________________________

Physician's Address: ____

I hereby authorize my physician to release medical information to Personnel Services, Capistrano Unified School District. I also authorize Personnel Services to contact my physician for eligibility determination purposes and to keep this information in confidence. I certify that the above information is true and correct to the best of my knowledge.

____ ______________
Signature Date

Distribution: Personnel Services, Payroll, Insurance, Employee Association, Employee

10/2004