# 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: _____
_____
_____

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

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Distribution: Personnel Services
Payroll
Insurance
Employee Association
Employee

10/2004