



ADMINISTRATIVE REGULATIONS

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February 7, 2020	

SICK LEAVE BANK (SLB)

Purpose

The purpose of the Sick Leave Bank is to provide additional sick leave days to members of the bank in the event of an unexpected extended catastrophic illness, non-elective surgery, or a disability due to injury.

General Provisions Definitions

A District employee may, by written request, donate earned local personal leave days to the Sick Leave Bank which become available to employees who, due to personal serious illness of a catastrophic nature or that of an immediate family member have exhausted all accumulated leave.

To initiate and solicit membership the Human Resources department shall establish an open enrollment period for employees to donate to the Sick Leave Bank.

The transfer of donated days to the bank is a voluntary action on the part of the person donating the days. Monetary reimbursement is not provided by either the District or the person receiving the donated days.

At the end of each school year, unused leave is rolled over to the new school year.

- **School Year:** For Sick Leave Bank purposes, the school year shall be from July 1 through June 30
- **Catastrophic:** A catastrophic illness or injury is a severe condition or combination of conditions affecting the mental or physical health of the employee or a member of the employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time and that forces the employee to exhaust all leave time earned by that employee and to lose compensation from the District. Complications resulting from pregnancy shall be treated the same as any other condition.
- **Immediate:** Immediate family as defined in accordance with Board Policy DEC (local)

Eligibility for Membership

To be eligible for membership in the Sick Leave Bank, the employee.

- Must be eligible for Family Medical Leave (FML qualifications; employee has worked for the district for at least 12 months and has worked at least 1250 hours in the preceding 12-month period).
- Must be eligible to earn and use sick leave in the District.
- Must enroll as a new member of the Sick Leave Bank during the open enrollment period by written completion of the membership application (D1-A).
- Must contribute three (3) or four (4) of earned local sick leave to the Sick Leave Bank upon initial enrollment in the bank. The required number of days shall apply to both full- time and, part-time employees.
- These three (3) or four (4) days, once donated to the bank to become a member, will be subtracted from the employee's local leave days available. All donations to the bank become the property of the bank and cannot be returned even upon cancellation of membership.
 - Members of the bank during the last school year who found it necessary to use the benefit of the bank must rejoin by donating three (3) or four (4) days or the actual number of days used (whichever is less).
- Members who want to increase their membership donation to add family to can do so at the beginning of the school year; by donating one (1) day.
- Members of the Bank who have not used the bank benefits are not required to donate additional days unless the bank days fall below two times the number of participating members.

Cancellation of Membership

Sick Leave Bank membership may be cancelled at any time by the employee with written cancellation of participation by the member.

The member shall lose the right to utilize the benefits of the Sick Leave Bank upon cancellation of membership.

Members who have previously cancelled membership may rejoin at any open enrollment period by meeting the enrollment requirements.

Contribution of Days

The transfer of donated days is a voluntary action on the part of the person donating the days. Contributed days shall be subtracted from the member's local sick leave record. Contributed days become the property of the Sick Leave Bank. All contributions shall remain in force and may not be returned even upon cancellation of membership.

Employees may not contribute unused local sick leave days to the Sick Leave Bank upon retirement. Monetary reimbursement is not provided by the donor by either the District or the person receiving the donated days.

District employees who are on any type of leave themselves (medical, developmental, or the like) may not donate leave until they return to an active work status for at least ten working days.

Annually, the Human Resources department shall review the bank balance. If it is determined that the balance may be sufficient to operate without the required yearly member donation (typically a balance equal to two to three times the number of returning members), the members will be notified that no donation of said year was required and that no deduction was made from their local sick leave. In this occurrence

members shall maintain membership and membership rights. The regular donation may be required, with member notification, at a later date.

Uses and Limitations

Only members of the Sick Leave Bank are eligible for donated leave. A member of the Sick Leave Bank may withdraw leave from the bank under the following conditions:

- Must have exhausted all accumulated state, local leave.
- Must have a catastrophic mental and/or physical illness and/or injury as defined above.
- Must submit a completed application to the Human Resources Department to request a withdrawal of leave from the Sick Leave Bank.
 - If the employee is unable to request leave from the Sick Leave Bank, a member of the employee's family or the employee's supervisor may submit the request.
 - The application must include a physician statement from the member's health care provider and other documentation as may be required by the Human Resources department.
- All withdrawals must receive prior approval by Bank Committee after a review of the member's documentation.
- Leave withdrawn from the Sick Leave Bank may only be used for the employee's personal illness and/or injury, or illness and/or injury of an immediate family member as defined above.
- Transferred days may not be used to extend work period of employment, nor shall donated days be approved beyond a 12-month period beginning with the use of donated leave.
- If a member who has received fewer than 30 days from the Sick Leave Bank returns to work and then is ill and/or injured again with the same or different illness, he/she may apply to the Sick Leave Bank for additional days needed. Each separate illness and/or injury must meet the initial criteria.
- A member of the Sick Leave Bank may withdraw a maximum of 30 days of leave per school year.
- Members of the bank during the last school year who found it necessary to use the benefit of the bank must rejoin by donating three (3) or four (4) days or the actual number of days used (whichever is less).
- A member shall lose the right to utilize the benefits for the Sick Leave Bank only by termination of employment or written cancellation of participation by the member at any time.

Sick Leave Bank Committee

The committee that reviews and acts on Sick Leave Bank leave request is chaired by the director of Human resources, the benefits specialist, and two other district employees who are members of the sick leave bank.

The committee may grant SLB days retrospectively, but only within the current Sick Leave Bank school year. The SLB committee may grant sick leave days prospectively if a medical provider confirms the need for continuing treatment or examination, and the member's accrued leave balance is at zero or cannot be reasonably expected to cover the projected need.

Duties and Responsibilities of the Sick Leave Bank Committee

- Review individually in a called meeting all request for catastrophic leave bank days.
- Determine the number of says approved, not to exceed 30 days' cumulative total in any Sick Leave Bank year, and
- Reserve the right to approve, disapprove, or modify the number of days requested.
- Respond in writing to all applicants for Sick Leave Bank within 10 working days following the committee's approval or denial of the request.
- Report all approved request to the payroll department.

Appeal

All decisions regarding the Sick Leave Bank may be appealed in accordance with DGBA(LOCAL), beginning with the Superintendent or designee.

Attachments	
Form Number: D1-A D1-B D1-C D1-D	Form Name: Sick Leave Bank Membership Application Request for Days from the Sick Leave Bank Authorization to Receive Personal Health Information Health Care Provider's Statement for the Sick Leave Bank
References: DEC (LOCAL), DGBA (LOCAL)	
Questions regarding this procedure should be addressed to : Director of Human Resources, 830-693-4357, ext. 1108 or Benefits Specialist at ext. 1109	
Approved:	
Date:	



SICK LEAVE BANK (SLB) MEMBERSHIP APPLICATION

Membership in the SLB is voluntary

Membership in the Marble Falls ISD Sick Leave Bank is available to any employee that qualifies for Family Medical Leave (FML qualifications; employee has worked for the district for at least 12 months and has worked at least 1250 hours in the preceding 12-month period.)

MEMBERSHIP

I have read the administrative regulations concerning the Sick Leave Bank benefits, located in the online employee handbook and Board Policy. To be eligible for membership in the Sick Leave Bank, the employee understands that three (3) or four (4) days, will be subtracted from the employee's local leave allocation. Three (3) days is for employee only and four (4) days is to include immediate family member.

- All donations to the Bank become the property of the Bank and cannot be returned even upon cancellation of membership.
- Members of the bank during the last school year who found it necessary to use the benefit of the bank must rejoin by donating three (3) or four (4) days or the actual number of days used (whichever is less).
- Members of the Bank who have not used the bank benefits are not required to donate additional days unless the bank days fall below two times the number of participating members.

I further understand that should I be absent from work and exceed the number of leave days remaining available for the current year, the local and state leave policy will be in effect. (DEC-Local)

I Request Membership - I am voluntarily requesting membership in the Marble Falls ISD Sick Leave Bank.

Employee Name: _____

Last 4 of Social Security Number: XXX-XX-_____

Campus/Dept. _____

Days Donated: _____(3) three or _____(4) four (please check one)

_____(1) (previously donated 3...want to donate one more to cover family)

I authorize the contribution of _____days donated into the Sick Leave Bank and the adjustment from my available local leave days is verified by the signature below.

Signature

Date

PLEASE RETURN FORM TO: **Benefits Specialist, Human Resources Department**



Request for Day from Sick Leave Bank (SLB)

Instructions:

1. Complete the SLB member portion below and the Employee Supporting Statement and attach it to your request.
2. Complete the authorization form for SLB Committee to receive personal health information form (D1-C).
3. Have the physician complete the health care provider statement form (D1-D).
4. Return this form along with completed attachments to the Benefits Specialist in Human Resources.

SLB Member Name: _____	Date of Request: _____
Address: _____ City/State: _____ Zip Code: _____	
Campus/Dept.: _____	Work Telephone: _____ Extension: _____
Home/Cell Telephone: () _____ - _____ Number of SLB days requested: _____	
Signature of Requestor: _____	

The following criteria must be met for an employee to be granted SLB days:

- Applicant must be a current member of the Sick Leave Bank (SLB).
- All other paid leave must be exhausted before SLB days can be applied.
- The catastrophic injury, illness, or circumstance must affect the employee or a member of his/her immediate family.
- The medical provider's statement must confirm the illness or injury meets the Board's definition of catastrophic.

Definition of immediate family:

- Immediate family as defined in accordance with Board Policy DEC (local)

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FOR USE BY THE SICK LEAVE BANK COMMITTEE

Approved catastrophic leave bank days for _____ days

Request denied. Explanation:

SLB Committee Signature: _____ Date: _____

EMPLOYEE SUPPORTING STATEMENT

Your statement is voluntary. You may wish to include information that you feel is important to your application for benefits, please print or type it below.

Your Name: _____
First Middle Initial Last

Days requested are for my own medical condition, or a family member's condition. If request is for a family member, please provide the name below:

First Middle Initial Last

Relationship to you: _____

If you are the parent/guardian, family member's date of birth: _____

Supporting Statement:

Employee Signature

Date



AUTHORIZATION TO RECEIVE PERSONAL HEALTH INFORMATION

Employee's Name: _____

Social Security #: XXX-XX-_____

Patient's Name: _____

Patient's Date of Birth: _____

Relationship to Member: _____

Employee's Authorization for Self or Minor Family Member

I am the employee described above and named in the Marble Falls ISD employee's application for sick leave bank benefits. I hereby authorize the Marble Falls ISD Sick Leave Bank Committee to receive personal health information regarding any physical and/or mental health condition of myself or my minor family member named above as patient for the purpose of determining my eligibility for Sick Leave Bank benefits.

Signature of Member: _____ Date Signed: _____

Adult Patient's Authorization (Family Member)

I am the adult patient described above and named in the Marble Falls ISD employee's application for sick leave bank. I hereby authorize the Marble Falls ISD Sick Leave Bank Committee to receive personal health information regarding my physical and/or mental health condition for the purpose of determining the employee's eligibility for Sick Leave Bank benefits.

Signature of Adult Patient: _____ Date Signed: _____

PLEASE RETURN FORM TO: **Benefits Specialist, Human Resources Department**

For Completion by the HEALTH CARE PROVIDER for Sick Leave Bank Application

Instructions to the HEALTH CARE PROVIDER: The employee listed has requested catastrophic leave for their own serious health condition or to care for your patient. Please answer fully and completely, all applicable parts below. Several questions seek a response as to frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and examination of the patient. Terms such as "unknown" or "indeterminate" may not be sufficient to determine a need for leave. Please sign the form.

RETURN FORM TO: Benefits Specialist, Human Resources Department via Fax 830-693-5685

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider Name and Business Address:

Telephone#: _____ Fax#: _____

Type of Practice/Medical Specialty: _____

Patient Name: _____

1. Diagnosis: Please include primary and list secondary conditions.

2. If pregnancy, state estimated due date: _____

3. Approximate date condition commenced: _____

4. Is the condition Emergent? Urgent? Elective?

5. Date first unable to work: _____

6. Date of first visit for this illness/injury: When did recent symptoms first appear or accident happen? _____

7. Was the patient admitted to a hospital, hospice or residential medical care facility? Yes No
If yes, please provide dates of admission/discharge.

8. Which medications, other than OTC, prescribed? _____

9. Nature of treatment(s) (include surgical procedure) _____

10. Was the patient referred to other health care provider(s) for evaluation or treatment? Yes No
If yes, state the nature of such treatments and expected durations of treatment.

11. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
 Yes No If yes, estimate the hours needed on an intermittent basis.

Hours per day: _____ Days per week _____ From _____ through _____

12. Explain the care needed by the patient and why such care is medically necessary: _____

13. Has the patient been released to work in his/her own occupation? Yes No In any occupation? Yes No
If no, when should the patient return to work? _____ Full time _____ Part Time _____

Additional Information: Use back if necessary.

Signature of Healthcare Provider _____ Date _____

PLEASE RETURN FORM TO: **Benefits Specialist, Human Resources Department via Fax 830-693-5685**