Atlanta Public Schools
Time Share Sick Leave Bank

APPLICATION FOR WITHDRAWAL

ATLANTA PUBLIC SCHOOLS TIME SHARE SICK LEAVE BANK

APPLICATION FOR WITHDRAWAL

Part I: Employee Information

Last Name: _____ First Name: _____

Lawson Number: _____ School/Location: _____

Primary Phone: _____ Job Title: _____

Work (preferred) Email Address: _____

Eligibility Questionnaire

TO BE COMPLETED BY APPLICANT.

Before completing this application, please review the Time Share Sick Leave Bank Guidelines for eligibility requirements.

1. Are you an active member of the Time Share Sick Leave Bank? Yes ○ No ◉
2. Is all of your available leave exhausted? (Local sick leave, personal leave, and annual leave.) Yes ○ No ◉
3. Are you currently eligible or receiving benefits from workers' compensation, short term disability, long term disability, or any other disability coverage provided by the District or personal policy? Yes ○ No ◉
4. Is this request for sick leave bank withdrawal for personal sickness or injury? Yes ◉ No ○
5. Has your condition resulted in the incapacity to perform your job function for a period of at least 12 months? Yes ◉ No ○
6. **If yes, list job functions impaired by your condition.**

7. **Is your condition life-threatening? (If so, appropriate documentation from a licensed medical provider must be attached.)** Yes ◉ No ○
8. Are you currently under the care & treatment of a licensed physician? Yes ◉ No ○
9. Number of days requested from Time Share Sick Leave Bank (Annual maximum - 30 days)? _____

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Illness or Injury Verification

TO BE COMPLETED BY A LICENSED PHYSICIAN OR DESIGNEE.

Patient's Name: _____

1. Is this patient currently under your care? Yes ◉ No ○

2. Describe the relevant medical facts, if any, related to the condition for which the employee seeks withdrawal from the APS Sick Leave Bank**. Please note that Time Share Sick Leave Bank eligibility requirements state that an employee must have** a life-threatening, catastrophic mental or physical illness or injury which results in the inability to engage in any substantial gainful employment by reason of any medically determinable mental or physical impairment which has lasted or can be expected to last for a continuous period of not less than 12 months, or result in death.

3. Is the employee unable to perform his or her job functions due to their condition? Yes ○ No ○

4. How long will the employee be incapacitated due to his or her medical condition?
   Estimated Beginning Date: _____
   Estimated End Date: _____

Name of Health Care Physician: _____

Signature of Health Care Physician/Designee: _____ Date: _____

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Employee Certification

BY SUBMITTING THIS FORM TO THE DIVISION OF HUMAN RESOURCES, I CERTIFY THAT:

- All the information provided in this application is accurate;
- I have read and understand the terms and conditions regarding the operation of the sick leave bank and that all decisions made by the Time Share Bank Committee are final and are not subject to appeal and/or grievance.

I agree to release the Time Share Sick Leave Bank Committee, Atlanta Independent School System, Atlanta Board of Education, and its individual members, employees, and agents from any liability as a result of actions or decisions taken by the Time Share Sick Leave Bank Committee.

I authorize the Division of Human Resources to contact the Health Care Provider listed above to provide additional information as necessary for this particular request.

Signature of Employee: _____ Date: _____