



**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

**NOTE: This Page is CONFIDENTIAL**

### 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.

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#### 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? \_\_\_\_\_

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#### 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)

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#### 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.

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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.

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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 \_\_\_\_

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7. **LIMITATIONS**

Standing \_\_\_\_ Walking \_\_\_\_ Bending \_\_\_\_ Use of hands \_\_\_\_ sitting \_\_\_\_

Climbing \_\_\_\_ Stooping \_\_\_\_ Lifting \_\_\_\_ Psychological \_\_\_\_ Other \_\_\_\_

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8. **PHYSICAL IMPAIRMENT (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		_____		_____

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**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 \_\_\_

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Date \_\_\_\_\_                      Attending Physician Signature \_\_\_\_\_

Phone # \_\_\_\_\_                      Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_