APPLICATION FOR CARROLL INDEPENDENT SCHOOL DISTRICT SICK LEAVE BANK BENEFITS

2021-2022

Name ____________________________Employee #______________ Birthdate___________

First date of absence ______________________ Date returning to work __________________

Injury/Illness causing the absences: ____

____

____

I am applying for Sick Leave Bank Benefits and authorize the physician named below to release information on this illness/injury and absences to the Carroll Independent School District.

Physician Name: _____________________________ Physician Telephone: ___________________

Employee/Designee Signature: __________________________ Campus/Department: ___________

Authorized Family Member Signature ______________________________ Date_______________

Apply as soon as possible (within 30 days) to avoid pay disruption or benefit loss. Eligibility is not determined until doctor's statement is received.

TO BE COMPLETED BY THE PHYSICIAN

FOR ALL ILLNESSES/INJURIES:

Earliest treatment or diagnosis date (to your knowledge): ___________________________________

Related pre-existing conditions: ____

____

FOR ALL SURGERIES: Could recommended surgery be scheduled during extended school breaks such as Summer or Christmas without being detrimental to this patient's health?

Yes? ________ No? _________

Anticipated treatments/therapies after initial release for work: _______________________________

____

This patient was (will be) unable to work from ____________________through __________________.

Physician Signature: __________________________________ Date: _______________

***************************FOR DISTRICT USE ONLY**************************

Eligible Member? ______ Eligible Absence? _______ 10 Consecutive Days? ________

SLB days used by member this term ________(max 25): Lifetime ________ (max 75).

	Consecutive eligible absences (or planned absences)	________
-	Balance of sick/personal leave	________
=	Maximum number of benefit days APPROVED	________

Not Approved for these reasons:____

____

Signature of Bank Officer: _________________________________Date: _________

Return all information to:

Human Resources Executive Director
Carroll Independent School District
2400 N. Carroll Avenue
Southlake, Texas 76092

CARROLL ISD
AUTHORIZATION FOR THE RELEASE OR USE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A:

Name: ______________________________ **Address:** ______________________________

____

Phone: ______________________________

I, ______________________, hereby authorize Carroll ISD to disclose protected health information to the

Sick Leave Bank for the purpose of **Sick Leave Bank Benefits.**

The Protected Health Information (PHI) is to be mailed or faxed to:
Carroll ISD
Personnel Services
2400 N. Carroll Ave.
Southlake, TX 76092
Ph: 817.949.8218, Fax: 817.949.8229

SECTION B:

The specific protected health information to be released is: **Medical documents pertaining to request for Sick Leave Bank Benefits.**

SECTION C: By signing below, I understand that:

- This authorization shall expire on ______________________ or until revoked by me in writing, whichever comes first.
  (Date or completion of "event")
- I have the right to revoke or cancel this authorization at any time by providing notice in writing to this office.
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my protected health information that has already occurred.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
- I am not required to sign this authorization.
- I have a right to inspect or copy the protected health information that will be used or disclosed as per this authorization.

SECTION D:

Signature of Individual or Authorized Representative: ______________________________

Print name of individual: ______________________________

Representative's legal authority to individual: ______________________________

Print name of Authorized Representative: ______________________________

Date: ______________________________

*****Important information and instructions for completing this form are on the reverse side*****

IMPORTANT INFORMATION AND INSTRUCTIONS FOR COMPLETING

I. Carroll ISD may release information pursuant to this signed authorization only if the form is completed thoroughly and all conditions listed on the completed form are met.

II. Instructions

Section A:

1) "Name," "Address," and "Phone Number" of the individual whose protected health information (PHI) is being released. If the form is being completed by an authorized representative or other legal authority, enter the name and address of the authorized representative or legal authority and enter the billing number of the individual whose PHI is being released. If the billing number is not known enter the "Social Security Number" of the individual whose PHI is being released.
2) "Name of individual" is the individual whose PHI is being released.
3) "Name of covered entity" is the agency or organization who has the individual's PHI which will be released.
4) "Who will receive the information?" is the person or organization who will obtain the PHI when it is released.
5) "Describe why this information is being released" means that you need to write why the PHI is being released to a third party.
6) Ensure to provide a complete address for the entity you want to receive the information.

Section B: Thoroughly specify what PHI is being released. Federal regulations (45 CFR 164.502) require that only the MINIMUM NECESSARY information needed to accomplish the intended purpose may be released.

Section C: The signed authorization is valid until the completion of the "event" or until it is revoked in writing by the individual who signed it, whichever comes first. "Event" may be defined as the reason the signed authorization is needed. For example, if the signed authorization is needed for an insurance claim to be processed and paid, the signed authorization is only valid until that occurs. It is recommended that the length of an authorization not exceed one year. In some situations the law may not allow us to release information to the entity you specified. If in such a situation you want us to instead mail copies of the protected health information directly to you, write your initials in the space provided.

Section D: The individual whose PHI is being released should sign and date the form. However, if the individual is not able to sign the form, the individual's authorized representative should sign and date it. If the form is signed by an authorized representative, the representative's "legal authority" to act on the part of the individual must be indicated. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released.