SIDE LETTER

The Board and the Association agree that the issue of employees donating sick leave to employees that suffer from a catastrophic illness shall be deferred to the Sick Leave Bank Committee, and that committee shall prepare a recommendation for the Board's consideration.

For the Collinsville Education Association, IEA-NEA:

Cheryl Pride / Sandra Kolb

1/4/05
Date

For the Board of Education of Collinsville Community Unit District No. 10:

James W Ackenhausen

1/9/06
Date

FORMS FOR EMPLOYEE CATASTROPHIC ILLNESS AND INJURY

DONATION OF SICK DAYS FORM

Non-returnable donation of sick days for the
Employee Catastrophic Illness and Injury Policy

Name of donating employee:_____

Current number of sick days:_____

Donation being made to:_____

Number of days donating:_____

Conditions for donations:_____

_____
Signature of donating employee

Submit to the Sick Bank Committee

Forms for Employee Catastrophic Illness and Injury

PHYSICIAN VERIFICATION FORM

THIS FORM IS TO BE COMPLETED BY A PHYSICIAN RELATIVE TO AN EMPLOYEE REQUESTING TO RECEIVE DONATED SICK DAYS UNDER THE EMPLOYEE CATASTROPHIC ILLNESS AND INJURY POLICY OF THE COLLINSVILLE UNIT 10 SCHOOL DISTRICT.

PATIENT NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

1. ILLNESS, INJURY, OR PREGNANCY TREATED: (BE SPECIFIC)

   _____

   _____

   _____

2. IS THE CONDITION RELATED TO:

   A. PATIENT EMPLOYMENT: YES _____ NO _____
   B. AUTO ACCIDENT: YES _____ NO _____
   C. ILLNESS: YES _____ NO _____

3. HAVE YOU SEEN THE PATIENT BEFORE THE ABOVE ILLNESS?

   YES _____ DATE FIRST SEEN _____ NO _____

4. IN YOUR JUDGMENT, IS THE PATIENT AT THE PRESENT TIME ABLE TO PERFORM THE DUTIES OF HIS/HER OCCUPATION FOR THE COLLINSVILLE SCHOOL DISTRICT?

   YES _____ NO _____

5. IF THE ANSWER TO NUMBER 4 IS “NO”, WHY IS THE PATIENT NOT ABLE TO PERFORM HIS/HER DUTIES? PLEASE BE SPECIFIC.

   _____

   _____

   _____

6. IS IT YOUR OPINION THAT THE PATIENT CANNOT EVER RETURN TO HIS/HER PRESENT DUTIES?
YES _____ NO _____

7. IF THE ANSWER TO NUMBER 6 IS "NO", WHEN DO YOU ESTIMAT THE PATIENT CAN RETURN TO WORK? DATE _____

8. PLEASE STATE OTHER COMMENTS THAT MIGHT BE HELPFUL TO THE SICK LEAVE BANK COMMITTEE IN MAKING A DECISION ON THE ABOVE LISTED PATIENT:

_____

_____

_____

DOCTOR'S NAME: _____

ADDRESS: _____

_____

PHONE: _____

DOCTOR'S SIGNATURE: _____

DATE SIGNED: _____

PLEASE RETURN THE COMPLETED FORM AS SOON AS POSSIBLE TO:

Sick Bank Committee
c/o Mr. Kevin Robinson
201 West Clay Street
Collinsville, IL 62234
Phone: 618/346-6350