

**CATASTROPHIC SICK LEAVE APPROVAL FORM  
FULL-TIME CERTIFIED/SUPPORT PERSONNEL**

**WASHINGTON COUNTY BOARD OF EDUCATION  
CHATOM, AL 36518**

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**Section I: Employee Information**

Name of Employee \_\_\_\_\_

Home Address \_\_\_\_\_

Social Security No. \_\_\_\_\_ School/Work Site Phone No. \_\_\_\_\_

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**Section II: Description of Illness/Injury**

**NOTE:** An employee must be a member of the Washington County School Board SLB and receive approval from the Board prior to participating in the catastrophic sick leave plan.

A description of my illness/injury is as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Employee's Signature**

\_\_\_\_\_  
**Date**

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**Section III: Attending Physician's Statement (REQUIRED)**

**NOTE:** A statement from the attending physician attesting to the need for the employee requesting catastrophic leave to be placed on extended leave.

Name of Physician \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone No. \_\_\_\_\_

**Physician's Statement (may be attached or written)**

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Based on my professional opinion, I estimate that the person whose name is shown in **Section I** will need to be away from his/her employment for \_\_\_\_\_ days, weeks, months (**circle one**)

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date**

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**Section IV: Board Action**

Recommended by Superintendent: YES\_\_\_\_ NO\_\_\_\_ Date \_\_\_\_\_

Approved by Board/Committee: YES\_\_\_\_ NO\_\_\_\_ Date \_\_\_\_\_

**Directions: Complete and return this form to the Superintendent's Office**