Exh. 1a.2

DENVER CITY INDEPENDENT SCHOOL DISTRICT
Denver City, Texas

Sick Leave Bank
Family Information Form

This sheet should be filled out by members who are requesting sick leave days because of illness in the immediate family or illness of a relative for whom the member is the major caregiver. Please attach this form to the completed "Request for Days from Sick Leave Bank" form.

The immediate family should include and be limited to:

1. spouse;
2. son or daughter, including a biological, adopted or foster child, a son- or daughter-in-law, a stepchild, a legal ward, or a child for whom the employee stands in *loco parentis*; and
3. parent, stepparent, parent-in-law, or other individual who stands in *loco parentis* to the employee.

Name of family member: _____

Birth date: ____/____/____ Relation: _____

Does this family member live with the employee: Yes _____ No _____

If the answer is no, please explain the extent of your obligations as a major caregiver for this individual:

_____

_____

_____

_____

_____

To my knowledge this condition did not exist on the day I joined the Sick Leave Bank. (This statement is waived for the 1996 initial enrollment period and for new employees at their first opportunity to join the bank.)

_____ _____
Signature of Member Date

DENVER CITY INDEPENDENT SCHOOL DISTRICT
Denver City, Texas

Sick Leave Bank
Attending Physician's Statement

Name of patient: _____

Name of DCISD employee: _____
(if different from the name of patient)

Nature of sickness or injury:

_____

_____

_____

Dates of treatment: _____

Dates hospitalized, if any, and name and address of hospital:

Date admitted: ____/____/____Date discharged: ____/____/____

Name of hospital: _____

Address: _____

To your knowledge, what is the earliest date the patient was treated for this condition?

_____

Is patient still under your care? Yes _____ No _____

For what period of time will the patient be unable to work?

_____

For what reason(s) would the patient need to miss work for this long?

_____

Date patient can return to work? _____

_____
Typed or printed name of physician

_____ _____
Signature of physician Date