ita
CTA/nea

CATASTROPHIC SICK LEAVE BANK

◆ REQUEST FOR WITHDRAWAL ◆

I understand that, if my request is approved:

- ***Thirty (30) days in the Bank will be reserved for my use.***
- ***In the event I am able to return to work prior to using all thirty (30) days, the remaining days shall be released back to the Bank for use by other eligible ITA Bargaining Unit Members.***
- ***In the event that my physician determines that I will be unable to return to work at the end of the thirty (30) days, I may apply for one (1) additional block of thirty (30) days. I may reapply any time after the twenty-fourth (24th) day of my use of the Bank, in order to avoid a lapse in coverage.***
- ***The Committee may require that I submit to a medical review by a physician of the Committee's choice. The Committee shall choose only a physician who qualifies under the negotiated insurance plan and the expense shall be bourn by the district. Refusal to submit to the medical review will terminate my eligibility for withdrawal from the Bank for the existing catastrophic illness or injury.***

Name: _____ _____ _____
Last First M.I.

Street Address: _____ P.O Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Assignment: _____ Work Site: _____

First day of Differential Pay: _____

Physician's Name: _____

Physician's Telephone Number: _____

Physician's Address: _____

I certify that the above information is true and correct to the best of my knowledge.

_____ _____
Signature Date

10/30/06