City of Chesapeake
Department of Human Resources
Post Office Box 15225
Chesapeake, VA 23328

Telephone: 382-6582
Fax: 382-8501

Part A - Application for Withdrawal of Sick Leave Bank Days

This section is to be completed by the employee.

Important: Read carefully before completing application.

To be eligible to apply for Withdrawal of Sick Leave Bank Days, you must be an active member of the Sick Leave Bank, have missed a minimum of 30 workdays and exhausted all sick leave, annual leave, compensatory leave and overtime leave. To apply for Withdrawal of Sick Leave Bank Days, you must complete Part A of this application form. Part B, the Statement of Health Care Provider form is to be completed by a licensed and practicing health care provider. It is your responsibility to provide the Review Committee (via the Department of Human Resources) with a completed copy of Part A and Part B and any information requested. You must apply while you are still employed in a regular part-time or regular full-time permanent position. Incomplete application forms will delay the processing of your claim.

Please complete and return to the Department of Human Resources.
(Please Print)

Employee's Name: ____
Last *First* *Middle*

Address: ____
Street *City* *State* *Zip code*

Social Security #: __ __ __ - __ __ - __ __ __ __

Date of Employment: ______________

Phone Numbers for Contact:

Home: ______________

Work: ______________

Alternate: ______________

Date Entered Sick Leave Bank: ____________

Last date you worked: ____________________

Department Name: ________________________

Position/Job Title: ________________

Please answer the following questions as they relate to the duties and responsibilities of your job with the City:

Length of employment in the above type of work: ________ ***(yrs/mos)***

1. ***Describe the duties of your job:***

____
____
____
____

2. ***How does your condition now prevent you from performing this job?***

____
____
____

3. *How many days have you lost from work during the past year because of your condition? _____ Explain:____*

____

____

4. *Has your condition resulted from any of the following: (Check Yes or No)*

   a. *Any occupationally related accident or illness from which Worker's Compensation benefits are payable.* ☐ *Yes* ☐ *No*

   b. *Intentionally self-inflicted injuries.* ☐ *Yes* ☐ *No*

   c. *Injury occurring in the course of committing a felony or assault.* ☐ *Yes* ☐ *No*

   d. *Service in the armed forces.* ☐ *Yes* ☐ *No*

   e. *War, insurrections, rebellion, or active and illegal participation in a riot.* ☐ *Yes* ☐ *No*

   f. *Cosmetic surgery or treatment, or surgery or treatment not deemed necessary by a Health care provider.* ☐ *Yes* ☐ *No*

5. *Explain fully all YES answers to questions in item 4. Identify each question by letter. Attach additional sheets if necessary.*

____

____

____

____

____

____

6. *Did your job at the time of your condition involve:*

   a. *The use of machines?* ☐ *Yes* ☐ *No*
   b. *Technical knowledge or special skills?* ☐ *Yes* ☐ *No*
   c. *Any special supervisory skills?* ☐ *Yes* ☐ *No*

7. *Have you filed for Worker's Compensation benefits?* ☐ *Yes** ☐ *No*

8. *Have you filed a claim for Social Security benefits?* ☐ *Yes** ☐ *No*

9. *Have you filed a claim for VRS Condition Retirement?* ☐ *Yes** ☐ *No*

11. *Have you filed a claim for Unemployment Compensation?* ☐ *Yes* ☐ *No*
    If YES, on what date did you file? ______________
    (Month/Day/Yr)

12. *Has your health care provider told you to restrict your activities in any way?* ☐ *Yes* ☐ *No*

    *If "yes," state name of Doctor and the restrictions:*_______________________________

    ____

* *NOTE: If you answered YES (to 5-8) please attach a copy of the decision.*

Please list the name and address of the health care provider(s) currently or most recently treating you:

Name of Health care provider	***Name of Health care provider***
Health care provider's Mailing Address	***Health care provider's Mailing Address***
Health care provider's Phone Number	***Health care provider's Phone Number***
How often do you see this health care provider?	***How often do you see this health care provider?***
Date you first saw this health care provider?	***Date you first saw this health care provider?***

13. Have you been hospitalized or treated at a health care practice/facility for your condition? ☐ Yes ☐ No If YES, please give name and address of hospital or health care practice/facility: ______________________________

14. Did you visit on an INPATIENT (overnight) basis? ☐ Yes ☐ No
If YES, give date of admission and date of discharge: ______________________________
Type of treatment received: ______________________________

15. Did you visit on an OUTPATIENT (no-overnight) basis? ☐ Yes ☐ No
If YES, give date of visit and type of treatment received: ______________________________

____

Note: If you have been in other hospitals or health care practice/facility for your illness, list the names and addresses, dates and reasons for the hospitalization or clinic visit and the type of treatment you received:

____

____

____

Authorization to Release Medical Information

I hereby authorize any health care provider, hospital, agency or other organization to disclose any medical records or other information regarding my condition to the City of Chesapeake's Medical Leave Review Committee.

Applicant's Signature and Date: ______________________________

I certify that all of the information I have given in this document is true.

Applicant's Signature and Date: ______________________________

Statement of Health Care Provider

City of Chesapeake
Department of Human Resources
Post Office Box 15225
Chesapeake, VA 23328

Contact Information:
Telephone: 382-6633
Fax: 382-8501

Part B - Application for Withdrawal of Sick Leave Bank Days

This section is to be completed by the employee/applicant's health care provider.

To: The Health care provider

The City of Chesapeake's Medical Leave Review Committee will review your report on this case to determine whether your patient is eligible to receive benefits provided by the Sick Leave Bank. To speed the processing of your patient's claim, please provide the Review Committee with all medical information requested below.

Your complete report is key to the prompt handling of your patient's claim. Thank you for your cooperation.

Patient's Name:	Social Sec. #	*Patient's Age:*	*Date of Patient's last examination or appointment:*

Patient History: ______________________________

____

Approximately when was the patient's condition first realized: ____________ *(mo/yr)*

____

Diagnosis: List any test results or disorders you have found; please be as specific as possible, stating how the disorder(s) restrict the patient:

____

____

____

____

____

Present Treatment:

____

____

____

Patient's Response to Treatment:

____

____

____

Was this treatment deemed medically necessary? ☐ *Yes* ☐ *No*

Part B – (cont.)

Prognosis: (The duration of condition as related to the usual duties of the patient's employment.)

____

____

Date of patient's next scheduled visit: ____________

1. **In your opinion, is this patient unable to perform the usual duties of his/her employment:** ☐ Yes ☐ No
2. **If your answer to #1 above is yes, what is the projected date that this patient can return to full performance of job duties**? ____________ (Mo-Day-Yr) **An estimated date is required.**

   2a. If applicable, would you recommend the patient apply for disability retirement?
   ☐ Yes ☐ No Comments: ____
3. **If your answer to #1 above is no, and the patient may return to work at this time, what restrictions, if any, would the patient have upon returning to work?** ________________
   ____
4. **If applicable, when can the patient return to partial performance of job duties and/or ½ day work schedule?** ________
   Mo-Day-Yr

Printed Name of Health Care Provider	**Address of Health Care Provider**
Health Care Provider's Signature (Date)	**Health Care Provider's Contact Information** Telephone Number: Fax Number:

PLEASE RETURN THE COMPLETED FORM TO:

City of Chesapeake
Department of Human Resources
Post Office Box 15225
Chesapeake, VA 23328

You may also Fax completed forms to Fax # 382-8501 (or) 382-8556