CRITICAL ILLNESS REQUEST LEAVE FORM

Effective 9/1/2023

PART I - TO BE COMPLETED BY EMPLOYEE

Name: _____ Assigned Building/Location: _____

Position: _____

Requested Critical Illness Dates of Leave (maximum 5 days): _____

Requested Sick Dates of Leave (as per policy): _____

Name of Immediate Family Member:_____ Relationship:_____

Employee's Signature: _____ Date:_____

PART II - TO BE COMPLETED BY PHYSICIAN

The above employee of Manalapan-Englishtown Regional School District is requesting to use critical Illness days for the dates above for their immediate family member.

Critical illness shall be defined as: [1] a life-threatening condition because of disease or injury; [2] a medical state in which death is possible or imminent; [3] an admission to a hospital for emergent care of a critical condition; or [4] surgery requiring the administration of anesthesia, as certified by a physician. Please note: Critical Illness leave cannot be used for dental services, elective surgeries/procedures, cosmetic surgeries/procedures, or pre-testing services.

Physician, please indicate if this request meets the criteria of a critical illness day: ____Yes or ____No

Diagnosis meeting the Criteria:_____

_____

Start Date of Critical Illness:_____ End Date of Critical Illness:_____

Physician's Stamp:

Physician's Signature: _____

Date: _____

PART III - TO BE COMPLETED BY ADMINISTRATION

Approved: Yes / No Rationale If No:_____

Manager of Human Resource's Signature: _____ Date:_____

Approved: Yes / No Rationale If No:_____

Superintendent's Signature: _____ Date:_____

Critical Illness days are granted on a case-by-case basis and will not be processed until the necessary documentation is received. If your day(s) is approved the Human Resources Department will update your attendance record to reflect the days.

This form will be placed in your personnel file.