

CITY OF NORFOLK
DEPARTMENT OF HUMAN RESOURCES
100 CITY HALL BUILDING, EAST WING
NORFOLK, VA 23510
Phone: (757) 664-4464

APPLICATION FOR WITHDRAWAL OF SICK LEAVE BANK DAYS

IMPORTANT: READ CAREFULLY BEFORE COMPLETING APPLICATION.

NOTE: SUPERVISORS ARE ENCOURAGED TO RENDER ASSISTANCE TO ANY EMPLOYEE WHO IS UNABLE TO COMPLETE THIS FORM.

To file for withdrawal of Sick Leave Bank days, you must complete this application form. The Physician's Certification of Disability form is to be completed by a licensed and practicing physician. It is your responsibility to provide the Review Committee with any information requested. Incomplete forms will delay the processing of your claim. You must apply while you are still employed in a permanent full-time or permanent part-time position. To be eligible to withdraw days from the Bank, you must be an active member, have missed a minimum of 30 work days, and have exhausted all sick leave, annual leave, and compensatory leave.

1. Name _____
Last First Middle
2. Address _____
3. Phone () _____
Area Code
4. Social Security No. - - _____
5. Employment Date _____
6. Position/Title _____
7. Department/Bureau _____
8. Length of employment in the above type work _____
9. Last date you worked _____
10. Describe the duties of this job _____

11. How does your disability now prevent you from performing this job?

12. Has your disability resulted from any of the following?:
(Check Yes or No)
- a. Any occupationally related accident or illness for 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, insurrection, rebellion, or active and illegal participation in a riot. YES NO
 - f. Cosmetic surgery, or treatment, or surgery or treatment not deemed necessary by physician. YES NO

13. Explain fully all YES answers to questions in item 12. Identify each question by letter. Attach additional sheets if necessary.

14. Did your job at the time of your disability involve:
- a. The use of machines, tools or equipment? YES NO
 - b. Technical knowledge or special skills? YES NO
 - c. Any special supervisory skills? YES NO

15. Explain all YES answers to questions in item 14. Identify each question by letter.

16. How many days have you lost from work during the past year because of your disability? _____

Explain: _____

17. Are you making application for retirement from a disability which is compensable under the Virginia Workmen's Compensation Act? [] YES [] NO
18. Have you filed for Worker's Compensation benefits? [] YES [] NO
(If YES, attach a copy of the decision)
19. Have you filed a claim for Social Security benefits? [] YES [] NO
(If YES, attach a copy of the decision)
20. Have you filed a claim for unemployment compensation? [] YES [] NO
(If YES, date claim filed _____)
21. Have you filed a claim for disability retirement? [] YES [] NO
(If YES, attach a copy of the decision)
22. Has your doctor told you to restrict your activities in any way? (If YES, state the name of the doctor and those restrictions) [] YES [] NO
23. List the names and address of the physicians currently or most recently treating you.

Name of Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____

Name of Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____

Name of Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____

24. Have you been hospitalized or treated at a clinic for your disability?
[]YES []NO . If YES, give name and address of hospital or clinic:

a. Were you an inpatient? (Stayed at least overnight) []YES []NO

Dates of admission: _____

Dates of discharge: _____

b. Were you an outpatient? []YES []NO

Dates of visits: _____

Name of Hospital or Clinic: _____

c. Type of Treatment Received:

25. If you have been in other hospitals/clinics for your illness, list the names, addresses, dates and reasons.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize any physician, hospital, agency or other organization to disclose any medical records or other information regarding my disability to the City of Norfolk Sick Leave Bank Review Committee.

Date Your Signature

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

Date Your Signature

PLEASE RETURN COMPLETED FORM TO DEPARTMENT OF HUMAN RESOURCES

HUMAN RESOURCES USE ONLY:

1. The Applicant is an active member of the City of Norfolk's Sick Leave Bank.

[] YES [] NO

2. The Applicant joined the Sick Leave Bank on _____
Month Day Year

3. The Applicant has _____ hours of sick leave, _____ hours of annual leave, and _____ hours of compensatory leave, as of the date of application.

4. The Applicant has missed _____ consecutive work days as of the date of application.

Signed

Title

DO NOT WRITE ON THIS PAGE - REVIEW COMMITTEE USE ONLY

Employee Name: _____

Social Security Number: _____

Department: _____

Bureau: _____

Request: _____ Approved _____ Disapproved

Committee Comments: _____

Signature/Chairman

Date

List dates of hospitalization, consultation, relevant past history to disability:

Diagnosis – List disorders you have found; be as specific as possible stating how the disorder(s) restricts the patient:

Present Treatment:

Response to Treatment:

Prognosis: (The duration of Disability as related to the usual duties of the patients employment)

1. In your opinion, is this patient totally and permanently disabled to perform the usual duties of his/her employment forever?

YES NO

2. If your answer to #1 above is NO, what is the projected date that this patient can return to full performance of job duties?

Month Day Year

3. If applicable, when can the patient return to partial performance of job duties?

Month Day Year

Signature of Physician: _____

Printed Name of Physician: _____

Address: _____
Street

City State Zip Code

Phone: () _____ Date: _____

Please Return the Completed Form to:
City of Norfolk, Department of Human Resources
810 Union Street, Norfolk, VA 23510