KEYSTONE CENTRAL SCHOOL DISTRICT

REQUEST FOR DISABILITY LEAVE, MEDICAL LEAVE OR CHILDBEARING LEAVE

Employee Name:	
Location of Employment:	Position:
Date Leave Begins:	Date Leave Ends:
Number of Sick Days to be Used:	Number of Personal Days to be Used:
Number of Additional Unpaid Leave Days:	
Type of Leave Requested**:** Disability ☐ Medical ☐ Childbearing ☐	

Disability leaves and childbearing leaves shall be subject to the same conditions as indicated below:

1. In addition to using paid leave time, an unpaid disability or childbearing leave shall be granted for an employee who is unable to work because of illness or disability, beginning when all other appropriate leaves have been exhausted, for up to twelve (12) months for district employees except those covered under the Clinton County Secretarial Personnel Association Agreement, which provides for up to eighteen (18) months of leave.

0. The employee must submit a request and a doctor's certificate, stating the nature of the disability and, if possible, an estimated recovery date. In case of an anticipated disability, such a request and certificate shall be submitted not less than thirty (30) calendar days prior to the leave, if medically possible.

0. Employees who are eligible for FMLA leave will be required to provide the necessary completed forms.

0. The employee returning from a disability leave may return to work five (5) working days after providing the Superintendent with certification by his/het physician that the employee is able to perform his/her job responsibilities.

0. During approved disability leave, the employee has the right to remain in the employer's group medical insurance plan by paying the premium at the school district business office. If an employee is eligible for FMLA leave and has provided the employer with the required documentation, the district will pay the cost of the employee's group medical as provided by law during the FMLA leave.

A physician's certificate or completed FMLA and HIPPA disclosure forms must be attached to this form.

_____ _____ _____

Signature of Employee | Date of Application | Date of School Board Approval

THIS FORM AND ALL MEDICAL CERTIFICATES ARE TO BE FAXED OR SCANNEDTO THE HR OFFICE AT (570) 726-2331.

****A Doctor's note must be received by the district five (5) days prior to your return-to-work date****
You must have a "Release to Work" note from your doctor before returning to work

KEYSTONE CENTRAL
SCHOOL DISTRICT
RESPECT FOR YESTERDAY • PRIDE IN TODAY • PLANS FOR TOMORROW

86 Administration Drive, Mill Hall PA 17751
Telephone: (570) 893-4900 Fax: (570) 726-2331
Web Site: www.kcsd.us

Justin Evey
Director of Human Resources

AUTHORIZATION FOR RELEASE/POSSESSION OF MEDICAL AND HEALTH INFORMATION AND/OR RECORDS

I, _____ (DOB:_____; Soc Sec No._____), hereby acknowledge and agree that certain of my medical and/or health information and/or records will be provided to or otherwise acquired by the Keystone Central School District. These records are being obtained and/or provided for the following purpose:

_____
_____.

These records and/or information include, but are not limited to, files, medical records, correspondence, office notes, photographs, medical charts, radiology films, data, bills, substance abuse records, mental-health records, counseling records, counseling records, insurance forms and HIV related information and all other documents, information and things that relate to me.

This consent is subject to revocation at any time except to the extent that the person and/or entity who is to make the disclosure or who will otherwise utilize the above records and/or information for the purpose described herein has already taken action in reliance upon it. I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein. I further hereby release the Keystone Central School District and its employees and agents from any and all legal responsibility or liability in connection with the release, re-disclosure or use of said records and/or information for the purpose as described herein. I further understand that if I wish to revoke this authorization, I must do so in writing to the attention of the Privacy Officer of any applicable healthcare providers or to the attention of the Keystone Central School District Supervisor of Human Resources, as the case may be.

I understand that this authorization is to be regarded as the written consent required by the Confidentiality of HIV Related Information Act, 35 P.S. §7607 and HIPPA, Pub. Al. No. 104 – 191 (August 21, 1996), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 & 164. This authorization will remain in effect for the duration of the purpose for which it is being obtained.

I acknowledge that the medical/health information disclosed to or otherwise possessed by the Keystone Central School District pursuant to this authorization may be subject to re- disclosure by the Keystone Central School District and no longer protected by federal privacy laws and regulations. A photo static copy of this Authorization shall serve in its stead.

_____
Date

_____
Name of Party *(Please Print)*

_____
Signature of Party