

La Porte Independent School District  
Catastrophic Sick Leave Bank

**REQUEST FOR SICK LEAVE BANK DAYS**

Last Name	First Name	MI	Employee ID#
Mailing Address			Phone Number (Home/Cell)
Campus Department		Position	
Date of Birth		Date of Request	

A. Number of days requested from the CSLB: \_\_\_\_\_

to

B. Reason for my request to the Catastrophic Sick Leave Bank: I am requesting days from the CSLB for the following reason: (as per CSLB Administrative Guidelines, Section III.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

C. I have used all of my accrued sick leave and vacation, if applicable. I am not currently receiving Worker's Compensation or other non-insurance salary reimbursement for the current condition.

D. I am currently a member of the Catastrophic Sick Leave Bank.

E. A completed statement from my physician is attached.

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

Please complete and return with Physician's Statement to:

La Porte Independent School District  
Payroll Office  
1002 San Jacinto  
La Porte, TX 77571  
Fax: 281-604-7119