Houston Independent School District
Leave Administration
Hattie Mae White Educational Support Center
4400 West 18th St., Houston, TX 77092
Ph: 713-556-6590 ◈ Fax: 713-556-6966 ◈ Email: LeaveAdministration@HoustonISD.org

Supplemental Sick Leave Bank (SSLB) Benefit Claim Form I: Confidential Member's Statement

Last Name:		First Name:	
Employee ID #:		Position:	
Work Phone #:	( ) -	Home/Mobile Phone #:	( ) -
Campus/Work Location:		Timekeeper Name:	
Timekeeper Phone #:	( ) -		
Information regarding claims is communicated exclusively via e-mail. Please provide an alternate e-mail address.	Your HISD E-mail Address:	@houstonisd.org	
	Personal E-Mail Address:		

- **Contact your timekeeper or supervisor for information to complete this form.**
- **You must notify your work-location supervisor of absences.**
- **You must be absent for seven (7) consecutive working days in order to be eligible for the program.**
- **All state, local, vacation, and compensatory leave must be exhausted before SSLB benefits will be approved.**
- **Requests for intermittent SSLB leave days will need to meet additional criteria, as outlined in Finance Procedures Manual: Section 1501 a-d.**
- **All absences must be reported, even if unpaid. Incorrect reporting will cause processing delays.**
- **Submit completed signed forms by fax, email, mail, or in person to Leave Administration.**
- **You must notify Leave Administration if you return to work before your SSLB claim end date.**

1. Are you currently a member of the Supplemental Sick Leave Bank?	❑ Yes	❑ No
2. Prior to this claim, have you applied for benefits during **this** SSLB plan year?	❑ Yes	❑ No
2a. If yes, are you requesting a direct extension to your prior claim? ❑ Yes ❑ No		
3. Have you exhausted all available leave (vacation, state, local)?	❑ Yes	❑ No
3a. If no, what date do you expect to exhaust all paid leave? ____/____/____ month / day / year		
4. Provide **last date you worked** before absences due to medical condition began.	____/____/____ month / day / year	
5. Have you returned to work?	❑ Yes	❑ No
6. Provide the date you returned or expect to return to work.	____/____/____ month / day / year	
7. Provide the number of days you are requesting payment from the SSLB. **Note:** Maximum is 30 full days, no partial days will be awarded.	**Days**	

By signing below, I hereby confirm that all the information provided in the member's statement (Claim Form I) and the physician's statement (Claim Form II) is true, and I am aware that false or misleading information may result in denial of my benefit claim(s). False actions on my part or on my behalf may be considered misuse of the Supplemental Sick Leave Bank program and my membership may be permanently terminated without payment.

Employee Signature: _____ **Date**: _____

Leave Administration Rep. Signature: _____ **Date**: _____