Columbus City Schools
Human Resources Administration
3700 South High Street
Columbus, Ohio 43207
PH: 614-365-6791
Fax 614-365-4044

Mission: Each student is highly educated, prepared for leadership and service, and empowered for success as a citizen in a global community.

Catastrophic Sick Leave
Instructions and Forms

Please complete the enclosed medical questionnaire and return to Columbus City Schools, 3700 S. High St., Columbus, Ohio 43207 by fax to 614-365-4044 or leavesofabsence@columbus.k12.oh.us as soon as possible.

Have your physician complete the Physician's Statement. We especially need #7 completed as to whether or not you are able to work, including the date that you are able return to work.

See the dates below for the next Catastrophic Leave committee meeting. ***We need to have all of the information to us by noon of the Wednesday prior to the meeting date.***

For assistance, please contact the Leave of Absence Department: 380-997-7574

Please note: Applying for and receiving donated days does not change the fact that you will need to be boarded for an unpaid leave of absence once your sick leave is exhausted. In addition, if applying for catastrophic sick leave, you will still need to contact Broadspire and have a medical leave of absence on file.

If you have applied for and are approved for *disability retirement*, you must notify Human Resources Administration immediately. Catastrophic Sick Leave donation may not be used to delay disability retirement.

Meeting Dates (Mondays):	
August 19, 2024	February 10, 2025
September 9, 2024	February 24, 2025
September 23, 2024	March 10, 2025
October 7, 2024	March 24, 2025
October 21, 2024	April 14, 2025
November 4, 2024	May 5, 2025
November 18, 2024	May 19, 2025
December 9, 2024	June 9, 2025 (Classified only)
January 6, 2025	July 14, 2025 (Classified only)
January 27, 2025	July 28, 2025 (Classified only)

COLUMBUS CITY SCHOOLS

MEDICAL QUESTIONNAIRE *(to be completed by employee)*

(Please type or print legibly)

1. Name _____ Birthdate _____
   Hire Date _____ Employee ID# _____
   Job classification _____ Work location _____
   Home and/or Cell Phone _____

2. Home Address _____
   (street) (city) (state) (zip)

If you are or expect to be elsewhere during absence from work, please provide details including address and telephone number.

_____
(street (city) (state) (zip) (telephone no.)

3. Please explain your catastrophic illness or injury. Give a detailed description. (Use a separate sheet if necessary) _____

4. On what date did you last work? _____ 20 ____

5. On what date were you first totally disabled by this catastrophic illness/injury? _____ 20 ____

6. On what date were you first treated by a physician for this catastrophic illness/injury? _____ 20 ____

7. Give full name and address of each physician who has treated you during this period of disability:

(name)	(address)	(zip code)	(phone)	(fax no.)

8. Explanation of Previous Sick Leave Usage. (Use separate sheet if necessary) _____

9. Date accrued leave (sick, personal and vacation, if applicable), was/will be exhausted. _____

10. Have you applied for or been approved for disability retirement? Yes _____ No _____

I authorize any physician, surgeon, or other person who has treated or examined me or whom I have consulted for any purpose, and any hospital, clinic, or institution at which I have been treated, examined, or confined, to divulge and make available to Columbus City Schools, or their designated representatives, any and all information concerning my catastrophic illness/injury including all psychiatric and psychological information and tests. This authorization shall be valid for one year from the date shown below. A photocopy of this authorization shall be as valid as the original.

Date completed _____ 20 ____ Employee's Signature _____

Please include a paragraph about yourself and why you are in need of Catastrophic Sick Leave ***(to be completed by employee)***

You may make copies of this page if additional space is needed.

TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Patient's name _____ DOB _____

2. Please state:

   (a) patient's complaints: _____

   (b) objective findings (including results of x-rays, lab tests, diagnostic studies, B/P etc if relevant)

_____

_____

3. Give all dates of treatments by you during this period of catastrophic illness/injury:
   Office: _____
   Hospital: _____

4. If the patient was confined as a registered bed patient in a legally constituted hospital during this period, answer the following:
   (a) Name and address of hospital or facility _____
   (b) Date of admission _____
   (c) Date of discharge: _____

5. If any surgical procedure was performed during this period of catastrophic illness or injury, please complete the following:
   (a) Date of Procedure _____
   (b) Procedure performed: _____

6. Based on your personal knowledge and treatment, how long has the patient been totally disabled solely by this catastrophic illness/injury, so as to prevent the patient from working?

   From: _____ to and including _____

7. Has the patient recovered sufficiently to return to work? Yes _____ No _____
   (a) if "yes", give the date the patient was able to return to work _____
   (b) if "no", when, in your opinion, may work be resumed? (*please do not use the terms "indefinite", "unknown", etc.)* If a definite date cannot be determined, please approximate in days, weeks or months how long total disability will continue from the date of the most recent treatment as indicated above.

8. Is the patient MENTALLY capable of transacting his/her duties with realization of the nature and consequences of such acts? Yes _____ No _____

Physicians name and title (Please type or print legibly)

_____ Phone _____

Specialty Board Certification _____

Office Address _____

Physician Signature: _____ Date _____