

**ST. CLAIR COUNTY COMMISSION**  
**REQUEST FOR DECLARATION OF EMERGENCY SICK-LEAVE**

Date of Request: \_\_\_\_\_

Employee Requesting Leave: \_\_\_\_\_

Department Name: \_\_\_\_\_

Position: \_\_\_\_\_ Pay Grade: \_\_\_\_\_

I, \_\_\_\_\_, do hereby affirm that my Department Head has received information concerning my eligibility for emergency sick-leave in accordance with Policy #802 revised April 10, 2007. The Department Head has shown by their signature below that they agree that I have satisfied the General Conditions, Unexpected Need, Exhaustion of Leave and Family Member (if applicable) Requirements set forth in Policy #802, and request that the Commission approve my request and declare me eligible to receive donated leave days from other St. Clair County employees. I am only eligible to receive donated leave from employees who are in either a higher pay grade or in a pay grade not more than five pay grades lower than my pay grade. Attached is a certification with an original signature of my treating physician or an eligible family member's treating physician as required.

Employee Signature: \_\_\_\_\_

Please check the appropriate box regarding who is ill:

- |                               |  |
|-------------------------------|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Family Member (check one below) |
|                               | <input type="checkbox"/> Spouse                          |
|                               | <input type="checkbox"/> Grandparent                     |
|                               | <input type="checkbox"/> Parent                          |
|                               | <input type="checkbox"/> Child's Spouse                  |
|                               | <input type="checkbox"/> Child                           |
|                               | <input type="checkbox"/> Spouse's Child                  |
|                               | <input type="checkbox"/> Grandchild                      |
|                               | <input type="checkbox"/> Spouse's Parent                 |
|                               | <input type="checkbox"/> Sibling                         |

Department Head Approval: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Employee meets the General Conditions, Unexpected Need, Exhaustion of Leave and Family Member (if applicable) Requirements of Policy #802 revised April 10, 2007)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Commission Approval: \_\_\_\_\_ Date: \_\_\_\_\_

Copy Sent to Department Heads for Posting on: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

**I hereby authorize any and all doctors, hospitals, psychiatrists, mental health institutions, psychologists, counselors, drug treatment facilities, pharmacists, and other such health care providers who have treated me to disclose my individually identifiable health information as described below.** *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.* The information shall be released to the St. Clair County Commission, the St. Clair County Administrator, the Personnel Department and/or their designees. The purpose of the disclosure is to assess eligibility for emergency leave under St. Clair County's policies and the authorization shall expire once the information is supplied.

---

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

### **Signature of Patient or Patient's Representative**

---

**Signature of patient or patient's representative**

---

**Date**

Printed name of the patient's personal representative: \_\_\_\_\_

Relationship to the patient, including authority for status as

Representative: \_\_\_\_\_

## CERTIFICATION OF TREATING PHYSICIAN FOR EMERGENCY LEAVE

Employee's Name: \_\_\_\_\_

Patient's Name (If different from employee): \_\_\_\_\_

Does the Patient have an illness, injury, impairment or physical or mental condition ("illness") that involves (1) inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility or (2) a condition that, although inpatient care is not required, requires continuing treatment by a health care provider?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

Is the illness such that the Patient is unable to work, attend school or perform other regular daily activities due to the illness for a duration of longer than two calendar weeks?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

Is the illness one for which the anticipated life expectancy is less than 6 months?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

---

---

---

If leave is required to **care for an employee's family member** with a serious health condition, **does the patient require the employee's care** for basic medical or personal needs?

Yes  No

Expected Duration: \_\_\_\_\_

---

Signature of Health Care Provider	Type of Practice
Print Name	Telephone Number
Address	Date

---

**To be completed by the employee needing family leave to care for a family member:**

State the care you will provide and an estimate of the period during which care will be provided:

---

---

---

---

---

Employee Signature

---

Date

179958.doc