Powell Co Board of Education,

Please consider my request for unpaid disability leave due to an injury I received at home. Beginning 4/9/24 running through my surgery that hasn't been scheduled yet and my recovery time expressed by my treating medical staff.

Thank you,

Megan Castle

Megan Castle

Leave Request Form and Statement

NAME: Megan Nichole Castle LOCATION: Bowen Elementary
DATE SUBMITTED: 4/11/2024

☐ **PERSONAL LEAVE:** REQUESTED UNDER THE TERMS OF POLICIES 03.1231/03.2231. (SEE NEXT PAGE FOR REQUIRED STATEMENT)

DATE(S) OF PERSONAL LEAVE: _____ TOTAL DAYS: _____ SUBSTITUTE NEEDED ☐

☑ **SICK LEAVE:** REQUESTED UNDER THE TERMS OF POLICIES 03.1232/03.2232. (SEE NEXT PAGE FOR STATEMENT THAT MAY BE REQUIRED)

DATE(S) OF SICK LEAVE: 4/9/2024 TOTAL DAYS _____ SUBSTITUTE NEEDED ☑

CHECK ONE: ☐ EMPLOYEE'S ILLNESS ☐ ILLNESS OF FAMILY MEMBER* ☐ MOURNING

IS SICK LEAVE BEING USED FOR EMERGENCY LEAVE PURPOSES, PURSUANT TO POLICY? ☐ YES ☑ NO

☐ **MATERNITY/ADOPTION/CHILDREARING LEAVE:** REQUESTED UNDER THE TERMS OF POLICIES 03.1233/03.2233.

ESTIMATED DATE(S) OF LEAVE _____ TO _____ SUBSTITUTE NEEDED ☐

☐ PAID MATERNITY LEAVE /NUMBER OF SICK LEAVE DAYS _____ ☐ UNPAID MATERNITY LEAVE

☐ PAID BIRTH OR ADOPTION LEAVE (NOT TO EXCEED 30 DAYS) /NUMBER OF SICK LEAVE DAYS _____

☐ UNPAID CHILDREARING LEAVE _____

☐ **JURY LEAVE:** REQUESTED UNDER THE TERMS OF POLICIES 03.1237/03.2237.

DATE(S) OF JURY LEAVE: _____ TOTAL DAYS: _____ SUBSTITUTE NEEDED ☐

☐ EMPLOYEE WILL SIGN OVER COURT-ISSUED JURY PAY CHECK TO DISTRICT.

☐ EMPLOYEE WILL REIMBURSE DISTRICT FOR ANY JURY PAY RECEIVED.

☐ **MILITARY/DISASTER SERVICES LEAVE:** REQUESTED UNDER THE TERMS OF POLICIES 03.1238/03.2238.

DATE(S) OF LEAVE: _____ TOTAL DAYS: _____ SUBSTITUTE NEEDED ☐

☐ **EMERGENCY LEAVE:** REQUESTED UNDER THE TERMS OF POLICIES 03.1236/03.2236. (SEE NEXT PAGE FOR REQUIRED STATEMENT)

DATE(S) OF EMERGENCY LEAVE: _____ TOTAL DAYS: _____ SUBSTITUTE NEEDED ☐

☐ BEREAVEMENT ☐ DISASTERS ☐ COURT /LEGAL ☐ OTHER, SPECIFY: _____

IS SICK LEAVE BEING USED FOR EMERGENCY LEAVE PURPOSES, PURSUANT TO POLICY? ☐ YES ☐ NO

I understand that if I have provided information that is not true, I may be subject to disciplinary action.

Megan Nichole Castle — *Employee's Signature*
4/11/2024 — *Date*

_____ — *Superintendent/designee's Signature Approving Leave as Requested*
_____ — *Date*

CHI Saint Joseph
Medical Group

Orthopedics, Sports Medicine &
Podiatry

Locations:
624 North Maysville Road
Mt Sterling, KY 40353
PH: 859-497-4144

1850 ByPass Road
Winchester, KY 40391
PH: 859-737-5188

101 JB Shannon Way
Flemingsburg, KY 41041
PH: 859-497-4144

211 Fountain Court, Ste 320
Lexington, KY 40509
PH: 859-264-9820

PH: 859-497-4144

FAX: 859-498-4137

Providers:
- Anup Chattha, MD
- James Rollins, MD
- Jan Veloso, DPM
- Frank Taddeo, MD
- Carrie Carter, PA-C
- Jenna Newkirk, PA-C
- Taylor Elam, PA-C
- Robert Coleman, PA-C
- Emily Bilan, PA-C
- Robert Harris, PA-C

_______ My provider has discussed these restrictions with me and I have initialed that I understand and agreed to the restrictions outlined

NOTES:

Revised 5/2023

WORK NOTE / WORK RESTRICTIONS

Name: Megan castle DOB: 8/2/90

Reason for Visit: (L) knee

- o Return to work full or usual duty on ____________
- X Unable to return to work until follow up
- o No work until return appointment on ____________
- o Return to work with the following restrictions on ____________
- o If unable to accommodate the following restrictions, the patient is to remain off work until the next appointment or when accommodations are met at work.

- o May lift/carry unassisted up to ____ pounds with **RIGHT** / **LEFT** arm
- o Limit push/pull to ____ pounds with **RIGHT** / **LEFT** arm
- o No driving commercial / personal vehicles
- o No prolonged standing / sitting / walking
- o No squatting / kneeling / climbing / crawling
- o No use of vibratory tools
- o No repetitive type work with the **RIGHT** / **LEFT** upper extremity
- o No forcible gripping with the **RIGHT** / **LEFT** hand
- o No overhead work with the **RIGHT** / **LEFT** arm
- o No over-the-shoulder work with the **RIGHT** / **LEFT** arm
- o No use of the **UPPER** extremity **RIGHT** / **LEFT**
- o No use of the **LOWER** extremity **RIGHT** / **LEFT**
- o No repeated flexion / extension of the **RIGHT** / **LEFT** ____________
- o No repetitive bending or twisting at the waist
- o Must wear boot / cast / sling / brace / Other: ____________
- o Keep cast / splint clean and dry
- o Keep surgical / injured area clean and dry
- o Sit down work ONLY
- o Stand no more than ____ hours without changing position
- o Sit no longer than ____ hours without changing position
- o Limitations of work hours/day: No more than ______ hours/day
- o Limitations of work hours/week: No more than _____ hours/week
- o Weight Bearing Status: ___NWB ___Partial WB ___ Full WB on
- o Other: ____________

STAFF SIGNATURE: [signature] **DATE:** 4/9/24

Claire Maxted PAC