APPLICATION FOR SICK LEAVE CREDITS
FROM SICK LEAVE BANK
ESTABLISHED PURSUANT TO THE COLLECTIVE BARGAINING AGREEMENT
BETWEEN THE STATE OF NEW YORK-UNIFIED COURT SYSTEM
- AND -
DISTRICT COUNCIL 37
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL
EMPLOYEES, AFL-CIO, AND LOCAL 1070

GENERAL INSTRUCTIONS TO APPLY FOR SICK LEAVE CREDITS

Answer all questions on the first two pages of this form; don't forget to sign at the bottom of this page; if the question is inapplicable, put N/A.

Print or type all your answers.

Attach a copy of any doctor's notes or medical documentation relevant to your claim.

Have your physician complete the Certificate of Attending Physician.**Don't forget to sign the release on the Certificate of Attending Physician.**

Forward your application request and the attachments directly to:

Deputy Director for Labor Relations
Office of Court Administration
25 Beaver Street - Room 1017
New York, New York 10004

Fax #
212. 401. 9048

If you have any questions regarding this application, please call the Labor Relations Office at (212) 428-2585 or call your union office.

NO PHOTO COPIES AND/OR SNAP OUT FORMS ACCEPTED.
IS THE ADDRESS BELOW DIFFERENT FROM YOU LAST CLAIM FORM? ____YES ____NO

EMPLOYEE TITLE_____

EMPLOYEE WORK LOCATION(COURT/ADDRESS)_____

_____

Employee Name	Home Phone No.			Social Security No.
Home Address				Anniversary Date
Work Address				Date of Birth
Is illness/injury/disability due to occupational cause?				Is illness/disability covered by Workers' Compensation or No Fault Insurance?
Did illness/injury/disability occur while you were on active duty in any Military, Naval or Air Force of any country? ____YES ____NO				
Name of Hospital Where Confined	Address		Zip Code	Telephone No.
Name of Attending Physician	Address	Zip Code	First Date of Treatment	Telephone No.
Nature of illness/injury/disability (if injury, give date)				

To all physicians, hospitals, clinics, dispensaries, sanitoriums, druggists, and all other agencies (including insurance companies, Blue Cross-Blue Shield). You are authorized to permit the Joint Sick Leave Bank Labor/Management Committee or its representatives to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions and medical expenses

of_____
(Print Name of Patient)

Such information may be used to the extent deemed necessary by the Joint Sick Leave Bank Labor/Management Committee to determine the validity of this request.

Date:_____ X_____

WHAT IS THE NATURE OF YOUR ILLNESS/INJURY/DISABILITY?

HOW WAS YOUR ILLNESS/INJURY/DISABILITY SUSTAINED (attach a copy of the incident report if available)?

HAVE YOU RETURNED TO WORK? _____IF SO, ON WHAT DATE? _____IF NOT, HOW LONG DO YOU EXPECT TO BE ABSENT FROM WORK DUE TO THIS ILLNESS/INJURY/DISABILITY?

What is Your Current Sick Leave Balance?_____hours_____minutes
What is Your Current Annual Leave Balance?_____hours_____minutes
What is Your Current Compensatory Time Balance?_____hours_____minutes

The Above Balances Are Based On The Time Sheet For The Period_____to_____

Do You Have Any Other Full- or Part-Time Employment? _____YES _____NO
If YES, Indicate Name and Address of Employer Below.

I certify that the above statements are correct and the information furnished by me in support of this application is true and correct.

_____ _____
Employee's Signature Date

NOTE: The Joint Sick Leave Bank Labor/Management Committee requires that an employee requesting sick leave credits must submit such request within **20 workdays** of either: the occurrence of the injury or the onset of the illness/disability; or, the first day of the absence due to the illness/disability, or when the employee's leave accruals are exhausted, whichever is later. **The date of postmark** to the Labor Relations Office will be considered the date of submission.

CERTIFICATE OF ATTENDING PHYSICIAN
FOR SICK LEAVE CREDITS FROM SICK LEAVE BANK
ESTABLISHED PURSUANT TO COLLECTIVE BARGAINING AGREEMENT
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NOTICE TO PHYSICIAN:

This Certificate is being submitted by your patient in support of a request for sick leave credits. In order to be eligible, an employee must have been necessarily absent from work on a full-time basis due to an illness/injury/disability.

AN EMPLOYEE'S REQUEST WILL NOT BE PROCESSED UNTIL SATISFACTORY MEDICAL DOCUMENTATION SUPPORTING THE NEED FOR HIS/HER ABSENCE IS RECEIVED. YOUR COOPERATION IN PROVIDING A DETAILED EXPLANATION OF THE EMPLOYEE'S CONDITION, TREATMENT AND PROGNOSIS FOR RECOVERY WILL AID IN PROMPT PROCESSING OF THE EMPLOYEE'S REQUEST. **PLEASE PRINT OR TYPE THE INFORMATION REQUESTED.**

1. Patient's Name: _____

2. Nature of illness/injury/disability: _____

2a. If Maternity, estimated date of delivery and type: _____

3. Describe whether these is any history or evidence of pre-existing injury/illness/disability: _____

4. Date of initial and subsequent treatment for this illness/injury/disability (include dates of surgical procedure): _____

5. Describe nature and extent of illness/injury/disability, when examined and, if applicable, any change of condition since last report:

_____

6. Date the patient will be able to perform work of any kind (*e.g.*, part time or light duty): _____

7. If able to perform some work, list the types of work limitations. _____

8. State probable date that employee will be able to resume the full duties of his/her position.

_____

9. Remarks: _____

_____

10. Physician's Certification:
I hereby certify that the information contained herein is true and correct to the best of my knowledge.

_____ _____
Print or Type Name of Physician Physician's Signature

_____ _____ _____
Address Telephone Number Date

11. Release Authorization:
I hereby authorize any Physician or Surgeon to release any information requested with respect to this application.

_____ _____
Employee's Signature Date

PLEASE RETURN THE ENTIRE APPLICATION TO: Deputy Director for Labor Relations
Office of Court Administration
25 Beaver Street - Room 1017
New York, New York 10004