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 -
THE CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE
CIVIL, CRIMINAL AND FAMILY COURTS

## GENERAL INSTRUCTIONS FOR SICK LEAVE CREDITS

**Answer all questions on both sides of this form:** 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, NY 10004

If you have any questions regarding this application, please call the Labor Relations Office at (212) 428-2521.

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

EMPLOYEE/TITLE_____

EMPLOYEE WORK LOCATION (COURT/JUDICIAL DISTRICT/ADDRESS)_____

| | | | | |
|---|---|---|---|---|
| Employee Name | Home Phone No. | | | Social Security No. |
| Home Address | | | | Date of Birth |
| Work Address | | | | |
| 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_____
(Employee's Signature)

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** or the date of personal delivery 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
BETWEEN THE STATE OF NEW YORK-UNIFIED COURT SYSTEM
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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. Date of initial and subsequent treatment for this illness/injury/disability (include dates of surgical procedure):_____

_____

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

_____

5. Is the patient unable to perform work of any kind?

_____

6. If able to perform some work, is the employee unable to perform any one or more of the duties of his/her job (see attached title standard)? If yes, list the specific duties that the employee is unable to perform.

_____

7. State probable date that employee will be able to perform some of all of the duties of his/her position. If able to perform only some duties, list the specific duties that the employee will be unable to perform (refer to title standard).

_____

8. If different from 7, state probable date that employee will be able to perform all of the duties of his/her position.

_____

9. If neither 6 nor 7 applies, is it necessary for the employee to be absent from work for treatment?_____

10. Remarks:_____

11. 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 TO: Deputy Director for Labor Relations
Office of Court Administration
25 Beaver Street - Room 1017
New York, NY 10004

JOINT SICK LEAVE BANK LABOR/MANAGEMENT COMMITTEE

Employee's Name:_____

Employee's Court/Agency:_____

Length of Service:_____years_____months

Nature of illness/injury/disability:

_____

Job Performance and attendance:

_____

Committee Decisions:

Deputy Director for Labor Relations (or designee) _____Grant _____ Deny

_____

Signature Date

President of Union (or designee) _____Grant _____Deny

_____

Signature Date

If the employee's request has been granted, please indicate below the amount of sick leave to be charged against the Sick Leave Bank and credited to the employee.

_____hours

Return all grant decisions to the employee's payroll office.

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FOR PAYROLL USE/OFFICE USE ONLY: