

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 COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY

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) 428-2920.

NO PHOTO COPIES, NOTES ON PRESCRIPTION FORMS AND/OR SNAP OUT FORMS ACCEPTED.
IS THE ADDRESS BELOW DIFFERENT FROM YOUR LAST CLAIM FORM? ___ YES ___ NO

EMPLOYEE/TITLE _____

EMPLOYEE WORK LOCATION (COURT/ADDRESS) _____

Employee Name	Home Phone No.	Social Security No.
Home Address		Date of Birth and Anniversary Date
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 days** 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 Deputy Director for Labor Relations 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 OR, IF NECESSARY, ATTACHED A DETAILED LETTER EXPLAINING THE EMPLOYEE'S CONDITION.

1. Patient's Name: _____
2. Nature of illness/injury/disability: _____
- 2a. If Maternity, estimated date of delivery and type: _____
3. Describe specifically whether there 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 patient will be able to do any work (e.g., part time or "light duty"): _____

7. List the types of work limitations, if a date has been entered for Number 6.: _____

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