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 in 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

Forward your application request and the attachments directly to:

Deputy Director for Labor Relations
Office of Court Administration
25 Beaver Street – Room 1049
New York, NY 10004
or FAX (212) 401-9048

If you have any questions regarding this application, please call the Labor Relations Office at 212-428-2585

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#	Social Security #
Home Address		Date of Birth and Anniversary
Work Address		
Is illness/injury/disability due to occupational cause?		Is illness/injury/disability covered by Worker's 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	Telephone #

Name of Attending Physician	Address	Zip	Date of First Treatment	Telephone #

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 examinations, treatment, history, prescriptions and medical expenses of _____
(PRINT NAME OF PATIENT)

Such information may be used to the extent deemed necessary by the Join Sick Leave Labor/Management Committee to determine the validity of the 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 Your 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 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 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
BETWEEN THE STATE OF NEW YORK-UNIFIED COURT SYSTEM
-AND-
THE COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY

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 OF TYPE THE INFORMATION REQUESTED OR, IN NECESSARY, ATTACH 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 illness/injury/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 1049
New York, NY 10004
omir FAX (212) 401-9048