

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 CIVIL SERVICE EMPLOYEES ASSOCIATION, INC.

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, New York 10004

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, 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  
BETWEEN THE STATE OF NEW YORK-UNIFIED COURT SYSTEM  
- AND -  
THE CIVIL SERVICE EMPLOYEES ASSOCIATION, INC.

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, New York 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

A letter regarding all grant decisions will be sent to the employee's time and leave and payroll office.

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FOR PAYROLL USE/OFFICE USE ONLY: