New York State Court Clerks Association

Security Benefits Fund

170 DUANE STREET • NEW YORK, NY 10013
OFFICE: (212) 941-5700 • FAX: (212) 941-5705

NYSCCA

Dear Member,

Attached you will find the Sick Bank Application.

Please complete this form in its entirety and either by mail or fax it to the address listed on the form.

Upon receipt, the Sick Bank Committee will review your request.

Determinations by the committee will be based on the following criteria:

1. Length of UCS service
2. Medical Documentation and Prognosis
3. Whether the applicant may perform "light duty work"
4. Prior attendance record
5. Prior Applications for Bank Credits and Credits Granted: and,
6. Any Other Circumstances deemed relevant by committee
7. The decision to grant or deny Bank Credits to a member, or the rate at which the grant is made, is not grievable or otherwise reviewable.

Sincerely,

The Sick Bank Committee

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 NEW YORK STATE COURT CLERKS ASSOCIATION

GENERAL INSTRUCTIONS FOR SICK LEAVE BANK 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

Attn: Frances Oneto

Fax # 212-401-9048

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)

DESCRIBE THE NATURE OF YOUR ILLNESS/INJURY/DISABILITY.

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

~~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: THERE WILL BE NO RETROACTIVE GRANTS OF BANK CREDITS.**

CERTIFICATE OF ATTENDING PHYSICIAN
FOR SICK LEAVE BANK CREDITS FROM SICK LEAVE BANK
ESTABLISHED PURSUANT TO COLLECTIVE BARGAINING AGREEMENT
BETWEEN THE STATE OF NEW YORK-UNIFIED COURT SYSTEM
- AND -
THE NEW YORK STATE COURT CLERKS ASSOCIATION

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 be 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, ATTACH A DETAILED LETTER EXPLAINING THE EMPLOYEE'S CONDITION.**

1. Patient's Name:_____

2. Nature of illness/injury/disability:_____

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

JOINT SICK LEAVE BANK LABOR/MANAGEMENT COMMITTEE

Employee's Name:_____

Employee's Court/Agency:_____

Length of Service:_____years_____months

Nature of illness/injury/disability:

_____

Attendance:

_____

Committee Decisions:

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

_____

Signature Date

Chairman, Board of Trustees (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.

FOR PAYROLL USE/OFFICE USE ONLY: