New York State Court Clerks Association Security Benefits Fund

170 Duane Street, New York. NY 10013
Office: (212) 941-5700 Fax: (212) 941-5705
www.nyscourtclerks.org

Dear Member,

Attached you will find the Sick Bank Application.

This form must be completed in its entirety and either mail or fax it to the address listed on the form. Incomplete applications will be automatically denied.

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 and in Clerk Series Title**
2. **Medical Documentation and Prognosis**
3. **Prior attendance record**
4. **Prior applications for Bank Credits and Credits Granted: and,**
5. **Any other Circumstances deemed relevant by committee**
6. **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

1. **Answer all questions on this form**. If the question is inapplicable, put N/A.

2. Print your answers.

3. Have your physician complete the **CERTIFICATE OF ATTENDING PHYSICIAN**. You may also attach a copy of any doctor's notes or medical documentation in support of your claim. **Notes on Prescription Pads Are Not Acceptable**.

4. **Timeliness of Application: The date of postmark, the date stamp on the FAX or the date of personal delivery** to the Office of Labor Relations will be considered the date of submission. Bank Credits cannot be used to cover absences that occur prior to the date of submission. YOU DO NOT HAVE TO WAIT UNTIL YOUR PHYSICIAN COMPLETES THE CERTIFICATE OF ATTENDING PHYSICIAN before you submit your application. You should submit your application as soon as possible; however, the application will not be considered until all the required information has been received.

5. Your completed application and attachments may be sent by mail to:

Deputy Director for Labor Relations
Office of Court Administration
25 Beaver Street – Room 1049
New York, NY 10004

OR by fax to 212-401-9048

For questions regarding this application, you may call:
NYSCCA at (212) 941-5700, or
Labor Relations Office at (212) 428-2585

APPLICATION FOR SICK LEAVE CREDITS – NYSCCA

1. Employee Name _____
2. Work Title _____
3. Work Location & Address_____
4. Home Address_____
5. Home Phone_____ 6. Best Phone Number_____
7. UCS Anniversary Date (if known) _____
8. Have you returned to work? _____

   A. If yes, on what date? _____

   B. If no, how long do you expect to be absent from work due to this illness, injury or disability?

_____

DO NOT LEAVE THIS ANSWER BLANK

9. In a few words,

   A. Describe your illness, injury or disability and the date it began:

_____

_____

   B. State how your illness, injury or disability occurred and attach any available incident report:

_____

_____

10. Do you plan to apply, or have you already applied for disability (SSI or other), Workers' Compensation, No Fault or Military benefits? _____ Yes _____ No

    If yes, which benefit? _____ Date of filing _____

APPLICATION FOR SICK LEAVE CREDITS (continued) - **NYSCCA**

11. If you were hospitalized, please list the dates and the name, address and phone number of the hospital:

_____

_____

12. List the name, address and phone number of your attending physician:

_____

_____

13. What was the first date of treatment? _____

14. Do you have any other full or part-time employment? _____Yes _____No

If Yes, indicate name and address of employer below:

_____

To all physician, hospitals, clinics, dispensaries, sanitoriums, druggists and all other agencies (including insurance companies). 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)

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

CERTIFICATE OF ATTENDING PHYSICIAN - NYSCCA

NOTICE TO PHYSICIAN:

This CERTIFICATE is necessary to support your patient's request for sick leave credits. It must support the patient's claim that their absence from work was and/or will be necessary on a full-time basis, due to an illness, injury or disability. No determination on your patient's request will be made 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 add in the prompt processing of the request.**

Please PRINT the information requested. You may also attach a detailed letter explaining the employee's condition (not required).

1. Patient's Name:_____ 1A. Date of birth: _____

2. A. Describe the current illness, injury or disability: _____

_____

_____

B. If there has been a change in the condition of the illness, injury or disability since you first examined the patient, please describe:_____

_____

3. Date(s) of initial and subsequent treatment for this illness, injury or disability (include dates of any surgical procedures)_____

_____

4. Date patient will be able to:

A. Resume full duties of position_____ B. Do any work (part-time)_____

5. Remarks: _____

_____

6. PHYSICIAN'S CERTIFICATION

I hereby certify that the information contained herein is true and correct to the best of my knowledge.

_____	_____	_____
Name of Physician PRINTED	SIGNATURE of Physician	Date

_____	_____
Address	Phone Number

7. PATIENT'S RELEASE AUTHORIZATION:

I hereby authorize any Physician/Surgeon to release information requested with respect to this application.

_____	_____	_____
Employee's Name PRINTED	Employee's SIGNATURE	Date

MAIL to: Deputy Director for Labor Relations
Office of Court Administration
25 Beaver Street – Room 1049
New York, NY 10004

OR

FAX to: 212-401-9048