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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 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. **Timelines 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 submissions. 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) 947-5700, 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 applied for disability (SSI or other), Worker' 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 physicians, 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

