nassau BOCES

DEPARTMENT OF HUMAN RESOURCES

Sick Leave Bank Request Form

Please complete form. Submit this form and medical documentation to:
Human Resources, Attn: Sick Bank Coordinator
Fax Number: (516) 396-2383

SUBMISSION REQUIRES THE SIGNATURE OF THE CSEA PRESIDENT

Name:_____ **Position:**_____ **Building:**_____

Employee ID:_____ **Number of years employed by Nassau BOCES:** _____

Last day worked prior to illness: _____ **Number of days requested**: _____

Have you previously received a sick leave donation? **Yes/No (circle one)**

If yes: Date received _____ **How many days**?:_____

Reason for current request: (check one)*

Illness/Injury of 30 consecutive calendar days that requires:

_____Hospitalization _____Institutionalization _____Confinement to Bed

OR

_____A complete inability to perform each and every regular duty
(The employee should provide a statement detailing the circumstances surrounding this illness/injury.)

*****Medical documentation must be provided at the same time that this form is submitted. Documentation should be on Doctor/Medical Center/Hospital/Medical Provider Letterhead and include information such as, but not limited to: diagnosis, procedures/surgeries, prognosis, additional medical necessary/recommended therapies, restrictions and limitations with regard to everyday functions and/or job related duties and next re-evaluation appointment.***

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Sick Leave Bank Committee to make all necessary investigations concerning this application. I further authorize the release of any records or information, including but not limited to, medical (e.g. FMLA), Workers' Compensation, State Retirement, or Social Security Disability that is sought in connection with this application. I agree to sign any additional release(s) that may be necessary for the disclosure of applicable medical information to the Committee. The Committee will keep confidential all submitted information and documents. Note: The Human Resources Department will block out your name before submitting your medical documents to the Committee for consideration of your request.

CSEA President:_____

CSEA Member Signature:_____ Date of Request:_____

FOR OFFICIAL HUMAN RESOURCES USE ONLY

Date Received in Human Resources_____

Last day active on payroll_____
(No accruals available/out of time)

Date Reviewed by Committee_____