NEW YORK STATE UNIFIED COURT SYSTEM

Rev. 06/25

APPLICATION FOR SICK LEAVE CREDITS FROM THE SICK LEAVE BANK

Established pursuant to the collective bargaining agreement between the New York State Unified Court System and the **NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION.**

Instructions

- Answer all questions on this form. If the question is inapplicable, put N/A.
- Print your answers.
- 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**.
- Timeliness of Application: The **date of delivery** to the Office of Labor Relations via fax or email 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.
- Your completed application and attachments may be sent by email to sickbank@nycourts.gov, please write "**NJDCEA**" in the subject line OR by fax to (212) 401-9048.
- For questions regarding this application, you may email sickbank@nycourts.gov, or call your union office.

Application for Sick Leave Credits - NJDCEA

Name _____ Work Title _____

Work Location _____ Address _____

Phone Number _____ Email _____ UCS Anniversary Date _____

Have you returned to work?..... ☐ Yes ☐ No

If '**Yes**', on what date?: _____

If '**No**', how long do you expect to be absent from work due to this illness, injury or disability?: _____

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

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

Do you plan to apply, or have you already applied, for disability (SSI or retirement), Worker's Compensation, No Fault or Military benefits?..... ☐ Yes ☐ No

If '**Yes**', which benefit?: _____ Date of filing: _____

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

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

What was the first date of treatment? _____

Do you have any other full or part-time employment?..... ☐ Yes ☐ No

If '**Yes**', indicate name and address of employer: _____

Authorization

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 the 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.

Patient Name _____

Employee Signature _____ Date _____

Certification

I certify that the above statements are correct and the information furnished by me in support of this application is true and correct.

Employee Signature _____ Date _____

NEW YORK STATE UNIFIED COURT SYSTEM
CERTIFICATE OF ATTENDING PHYSICIAN - NJDCEA

Rev. 06/25

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 aid in the prompt processing of the request.**

Instructions

- Please PRINT the information requested.
- You may also attach a detailed letter explaining the employee's condition (not required).
- Submit by email to sickbank@nycourts.gov, or fax to (212) 401-9048.

Patient Information

Name _____ Date of Birth _____

Describe the current illness, injury or disability. If maternity related, please set forth the estimated date and type of delivery:

Describe any changes in the condition of the illness, injury or disability since you first examined the patient:

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

Date patient will be able to: Resume full duties of position _____ Do any work (part-time) _____

Remarks:

Physician's Certification

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

Physician Name _____ Phone Number _____

Address _____

Physician Signature _____ Date _____

Patient's Release Authorization

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

Employee Name _____

Employee Signature _____ Date _____