

APPLICATION FOR A&R SICK LEAVE BANK USE
(Article 20, A&R Contract)

TO BE COMPLETED BY EMPLOYEE AND FORWARDED TO AGENCY HEAD OR LABOR RELATIONS DESIGNEE:

Name: _____

Home Address: _____

Agency: _____

Official Class Title: _____

The applicant hereby authorizes access by the Sick Leave Bank Committee to any medical or personnel records necessary for action on this application. Applicant further certifies that he/she has carefully read the Sick Leave Bank Guidelines attached hereto, has received a copy thereof, and agrees to comply therewith.

Signature of Applicant

Date of Application

* * * * *

TO BE COMPLETED BY AGENCY LABOR RELATIONS DESIGNEE AND FORWARDED TO THE OFFICE OF LABOR RELATIONS, A&R SICK LEAVE BANK COMMITTEE:

- | | Yes | No |
|---|-------|-------|
| 1. Has applicant been employed by the State for at least two (2) years? | _____ | _____ |
| 2. Is applicant a member of the A&R (P-5) bargaining unit? | _____ | _____ |
| 3. (a) Has applicant exhausted all sick leave? | _____ | _____ |
| (b) Give date on which all sick leave will be/was exhausted. _____ | | |
| 4. (a) Has applicant exhausted all personal leave? | _____ | _____ |
| (b) Give date on which all personal leave will be/was exhausted. _____ | | |
| 5. (a) Has applicant exhausted all compensatory time? | _____ | _____ |
| (b) Give date on which all compensatory time will be/was exhausted. _____ | | |
| 6. (a) Has applicant exhausted all but sixty (60) days vacation credit? | _____ | _____ |
| (b) Give date on which all vacation in excess of sixty (60) days will be/was exhausted. _____ | | |

- | | Yes | No |
|--|-------|-------|
| 7. (a) Is illness or injury covered by Workers' Compensation? | _____ | _____ |
| (b) If yes, has worker's compensation benefit been exhausted? | _____ | _____ |
| 8. Is applicant a full-time permanent employee? | _____ | _____ |
| 9. Is acceptable medical certificate supporting the entire absence on file? | _____ | _____ |
| 10. (a) Give date of commencement of illness or injury for which Sick Leave Bank benefits are being requested. _____ | | |
| (b) Give date applicant first returned to work after illness/injury. _____ | | |
| 11. Please attach the following: | | |
| (a) copies of all medical certificates on file pertaining to the current illness/injury. | | |
| (b) Copy of applicant's attendance record applicable to this illness/injury. | | |
| (c) Copy of record of any disciplinary action taken for abuse of sick leave. | | |

Completed by:

Signature

Date

* * * * *

ACTION BY THE &R SICK LEAVE BANK COMMITTEE: _____

APPROVAL OF THIS APPLICATION FOR USE OF SICK LEAVE BANK IS HEREBY GRANTED TO COMMENCE ON: _____

AND, UNLESS RENEWED, WILL TERMINATE ON: _____

The agency is authorized to compensate the employee at the rate of one-half (1/2) day for each day of illness or injury up to a maximum of one hundred (100) full days (or 200 1/2 days) per contract year (July 1 through June 30). No vacation, sick leave, holiday or other paid leave benefits will accrue during the period applicant is receiving benefit hereunder.

WHEN AN EMPLOYEE RETURNS TO WORK, OR WHEN SICK LEAVE BANK BENEFITS HAVE BEEN EXHAUSTED, THE EMPLOYER WILL NOTIFY THE STATE DESIGNEE AT THE OFFICE OF LABOR RELATIONS, IN WRITING, WITH THE TOTAL NUMBER OF HOURS USED BY SAID EMPLOYEE.

FOR THE A&R SICK LEAVE BANK COMMITTEE:

Signature

Date

Signature

Date