Rev. 06/30/26

APPLICATION FOR A&R SICK LEAVE BANK USE

(Article 20, A&R Contract)

TO BE COMPLETED BY EMPLOYEE AND EMAIL TO POD5: DAS.BenefitsandLeavesPOD5@ct.gov

Employees 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, and has received a copy thereof, and agrees to comply therewith.

_____ _____

Signature of Applicant **Date of Application**

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TO BE COMPLETED BY BENEFITS AND LEAVES POD5 AND FORWARDED TO THE OFFICE OF LABOR RELATIONS, AND A&R SICK LEAVE BANK COMMITTEE.

	YES	NO
1. Has the applicant been employed by the State for at least six (6) months?	☐	☐
2. Is the applicant a member or A&R (P-5) bargaining unit?	☐	☐
3. Has the applicant exhausted all sick leave?	☐	☐
a. Provide date on which all sick leave will be/was exhausted: _____		
4. Has the applicant exhausted all personal leave?	☐	☐
a. Provide date on which all personal leave will be/was exhausted: _____		
5. Has the applicant exhausted all compensatory time?	☐	☐
a. Provide date on which all compensatory time will be/was exhausted: _____		
6. Has the applicant exhausted all but sixty (60) days' vacation credit?	☐	☐
a. Provide date on which all vacation in excess of sixty (60) days will be/was exhausted: _____		
7. Is the illness or injury covered by Workers Compensation?	☐	☐
a. If YES, has workers compensation benefit been exhausted?	☐	☐
8. Is the applicant a full-time permanent employee?	☐	☐
9. Is there an acceptable Medical Certificate supporting the absence on file?	☐	☐

10. Sick Leave Bank Benefit:
    a. Date of commencement of illness or injury requested _____
    b. Date applicant first returned to work after illness/injury _____

11. Please attach the following: Y
    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**

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ACTION BY A&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 two hundred (200) days paid at one-half (1/2) day rate, per contract year (July 1 through June 30). No vacation, sick leave, holiday or other paid leave benefit will accrue during the period applicant is receiving benefit hereunder.

WHEN AN EMPLOYEE RETURNS TO WORK, OR WHEN SICK LEAVE BANK BENEFITS HAVE BEEN EXHUASTED, 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 A&R SICK LEAVE BANK COMMITTEE

_____ _____
Signature Date

_____ _____
Signature Date