PROVIDENCE TEACHERS UNION AFT AFL • CIO

EMERGENCY SICK LEAVE BANK
Request for Emergency Sick Leave Days
(Please print or type all required information)

Date of Application_____

Name _____
(Last) (First) (Middle Initial)

Home Address_____

City/Town_____State_____Zip_____

Employee ID No. _____ D.O.B. _____

Is this a work related injury? Yes ☐ No ☐

Date Sick Leave Account will be exhausted: _____

Number of ESLB Days Requested: _____

I understand that in order to be granted ESLB days, I must attach a medical certification form completed by my attending medical provider. I also understand that a copy of the medical certification provided will be forwarded to the Providence Public School District Office of Human Resources once my request is granted. Each initial grant of sick leave days shall be limited to a maximum of 60 consecutively scheduled workdays. Additional days may be requested by submitting a new application with supporting medical documentation.

_____ _____
Signature of Applicant Date

SICK LEAVE BANK DETERMINATION FORM
(To be completed by Sick Leave Bank Chairperson)

Request Approved Yes ☐ No ☐ Date:_____

Number of Days Approved: _____

Effective Dates: Beginning Date: _____ Ending Date: _____

Comments:_____

_____

Approval _____
Signature of ESLB Chairperson