Providence Teachers Union
Emergency Sick Leave Bank
Request for Emergency Sick Leave Days
(Please print or type all required information)

Name_____

_____

(Last) (First) (Middle Initial)

Home Address_____

City/Town_____State_____Zip_____

Social Security Number_____ D.O.B. _____

Date Sick Leave Account will be exhausted_____

Number of Additional Sick Leave Days Requested_____

It is hereby agreed and understood that the Emergency Sick Leave Bank Committee reserves for itself the right to review my previous record with respect to the use of sick leave days.

_____

Signature of Applicant Date

Certification by Attending Physician

Please certify here on the nature of the illness/injury, the amount of time that you anticipate that the applicant will be absent from work, the prognosis and/or treatment, and the anticipated date of return to work.

_____

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_____

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_____

_____

Signature of Physician

Date

_____

Name of Physician Office Phone # of Physician

_____

Office Address of Physician

Providence Teachers Union
99 Corliss Street
Providence, RI 02904