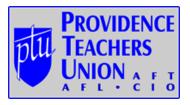


EMERGENCY SICK LEAVE BANK Request for Emergency Sick Leave Days (Please print or type all required information)

| Date of Application | | | | |
|------------------------------|---------------|---------|------------------|----------|
| Name | | | | |
| (Last) | | (First) | (Middle Initial) | |
| Home Address | | | | |
| City/Town | | State | Zip | <u> </u> |
| Employee ID No | Phone No.: | | D.O.B | |
| Date Sick Leave Account will | be exhausted: | | | |
| Number of ESLB Days Reque | ested: | | | |

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 App | proved: | | | |
| Effective Dates: | Beginning Date | e: | Ending Date: | |
| Comments: | | | | |
| | | | | |
| | | Approval | Signature of ESLB Chairperson | |



99 Corliss Street Providence, RI 02904 Phone: (401) 421-4014 Fax: (401) 421-9239

Medical Certification by Attending Medical Provider (To be <u>completed</u> by physician)

| Applicant Name: | Social Security No.: |
|---|----------------------|
| Is this a work-related injury? Yes No | |
| Is this an elective procedure? Yes No | |
| Please complete ALL sections. | |
| Please certify the <u>nature of the illness/injury</u> , the <u>amoun</u> <u>absent from work</u> , the <u>prognosis</u> , the <u>treatment</u> , and the | |
| Medical Diagnosis: | |
| | |
| Treatment: | |
| | |
| What precludes the applicant from working? | |
| Prognosis: | |
| | |
| Anticipated date of return to work: (month, day & | year) |
| Signature of Medical Provider | Date |
| Medical Provider Name & Address (Please Print) | Office Phone Number |
| | |
| | |

Emergency Sick Leave Application Checklist

The following steps must be completed for your application to be processed. Applications must be received prior to sick days being exhausted as days will not be granted retroactively.

- Complete ALL sections. Failure to do so will result in a denial of your application.
 Medical information must be completed by a licensed medical professional. Failure to do so will result in a denial of your application.
- 3. Submit doctor's note to Human Resources.



Providence Teachers Union 99 Corliss Street Providence, RI 02904

EMERGENCY SICK LEAVE BANK

RELEASE OF MEDICAL INFORMATION

(Please print or type all required information)

| I, | | , authorize |
|-----------------------------------|--------------|------------------|
| (Last Name) | (First Name) | (Middle Initial) |
| | | |
| | | |
| Name of Licensed Medical Provider | | Office Phone No. |
| | | |

Licensed Medical Provider Address

to release medical information to the Providence Teachers Union Emergency Sick Leave Bank Committee, including but not limited to, the nature of my illness/injury, the amount of time that I am expected to be absent from work, my prognosis and/or treatment and my anticipated date of return to work.

Signature

Date