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. _____ Phone No.: _____ D.O.B. _____

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

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

Medical Certification by Attending Medical Provider (To be completed 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 nature of the illness/injury, the amount of time that you anticipate that the applicant will be absent from work, the prognosis, the treatment, **and** the anticipated date of return to work.

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.

1. Complete ALL sections. Failure to do so will result in a denial of your application.
2. 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