Arlington Central School District | Office of Human Resources

SICK BANK FORM INSTRUCTIONS

1. Employee completes *Sick Bank Request Form*.

2. Doctor completes *Sick Bank Physician's Statement*.

3. Employee sends both forms to:

Roberta Kaiser
Administrative Assistant to the Assistant Superintendent for Human Resources
Arlington Central School District
144 Todd Hill Road
LaGrangeville, NY 12540
rkaiser@acsdny.org

OR

Your Sick Bank Representative

Please Note:

The Sick Bank Committee will only consider approval for sick bank days from the time that the request is received.

Maternity:

When requesting sick bank days for disability before the baby is born, your doctor **must** indicate your anticipated delivery date on the *Sick Bank Physician's Statement*. Days will only be counted up to this date.

Once the baby is born, you must have your doctor fill out a new *Sick Bank Physician's Statement* indicating the actual delivery date. Please return to the address above.

Arlington Central School District | Office of Human Resources

SICK BANK REQUEST FORM

Name: _____ Position: _____

Mailing Address: _____

_____

Home Phone: _____ Personal Email: _____

School Building: _____ Bargaining Unit: _____

Sick Bank Start Date*: _____ End Date: _____

The Sick Bank Committee will only consider approval for sick bank days **from the time that the request is received. FMLA leave will run concurrent with any disability.*

Estimated Return-to-work Date: _____

Comments: _____

_____

☐ I have attached my Physician's statement

_____ _____

Employee Signature Date

For Office Use Only:

Approved: Yes, dates: _____ through _____ Total # of days: _____

No, reason:

_____

_____

_____

Committee Member Name (please print)

_____ _____

Committee Member Signature Date

Employee Sick Bank Request #: _____ Employee Total Days for School Year _____

___ ***decision sent to member*** ***cc:*** ___ ***payroll*** ___ ***benefits*** ___ ***attendance***

4/21/2023

Arlington Central School District | Office of Human Resources

SICK BANK PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PATIENT

Patient Name: _____

Address: _____

_____

Phone: _____

_____ _____

Patient Signature Date

TO BE COMPLETED BY PHYSICIAN - PLEASE RETURN TO PATIENT

Detailed description of disability, including: surgery date (if applicable), treatment plan, and prognosis. (Attach additional pages if needed):

_____

_____

_____

If pregnant, anticipated delivery date: _____

Patient is under my care and unable to work from _____ through _____

Date patient can return to work: _____

Physician's name (please print): _____

Phone: _____

Address: _____

_____

_____ _____

Physician Signature Date