Poughkeepsie Public School
PPSTA
Teachers' Association

TO REQUEST SICK BANK DAYS:

-Print the following two forms, entitled REQUEST FOR WITHDRAWL OF SICK BANK DAYS and

DOCTOR CERTIFICATION FORM.

-Send these two completed forms along with a letter from your doctor stating the specific reasons for which you are unable to perform professional duties to:

Amber Grant, PPSTA Sick Bank Chairperson

Email: sickbank@ppsta.org

Address: Poughkeepsie High School

70 Forbus Street

Poughkeepsie, NY 12603

Note: The letter from your doctor should also be sent to Sheryl Small at 11 College Ave. Poughkeepsie, NY 12603.

ADDITIONAL INFORMATION:

-It is recommended that you submit your request two weeks before days are needed from the Sick Leave Bank.

-You must use **ALL** of your allotted sick leave days before requesting days from the Sick Leave Bank for the remainder of the time you need to be out. If in doubt about the number of sick days you have, contact Sheryl Small at 451-4900 Ext. 4970.

- The maximum number of days that can be requested from the Sick Leave Bank is 30 days. If more days are needed the entire process needs to be repeated.

If you have any questions, please contact Amber Grant at sickbank@ppsta.org.

POUGHKEEPSIE PUBLIC SCHOOL TEACHERS' ASSOCIATION

REQUEST FOR WITHDRAWL OF SICK BANK DAYS

DATE: _____

TO: SICK LEAVE BANK, Poughkeepsie Public School Teachers' Association

FROM: _____ SCHOOL: _____

ADDRESS: _____ PHONE #: _____

_____

As a member enrolled in the Sick Leave Bank, I find that I have used up all of my accumulated sick leave days and request that _____ days be withdrawn from the Sick Leave Bank in my name to cover my extended illness/disability from _____ to _____.

(start date) (end date)

I will forward the completed DOCTOR CERTIFICATION FORM and a letter from my doctor to verify this illness/disability.

The nature of this disability is (please be specific):

_____

_____

_____

_____

(Member's Signature)

Doctor's Name: _____

Doctor's Address: _____

_____

Doctor's Phone #: _____

POUGHKEEPSIE PUBLIC SCHOOL TEACHER'S ASSOCIATION

DOCTOR CERTIFICATION FORM

DATE: _____

TO: SICK LEAVE BANK, Poughkeepsie Public School Teachers' Association

I hereby certify that _____

(patient's name)

has been under my care for (please be specific)

_____.

(illness/disability)

Due to this illness/disability this person has been/will be unable to perform their professional duties on the following dates:

Complete A or B.

A. _____ thru _____

(start date) (end date)

B. Starting _____, and will be able to return to work on or about _____.

Complete C or D if illness/disability is related to pregnancy.

C. This is a prenatal disability. The projected delivery date is _____.

D. This is a postpartum disability. The actual delivery date was _____.

Complete E if surgery is to be/has been performed.

E. This patient's treatment will include/included

_____

(procedure)

which will be/was performed on _____.

(date)

Please attach a letter stating the specific reasons, for which the patient is unable to perform professional duties.

_____

(Doctor's Signature)