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the Sick Leave Bank, I find that I have used up all of my accumulated sick leave days and request that _______ days be withdrawn from the Sick Leave Bank in my name to cover my extended illness/disability from ______________ to ______________.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