POUGHKEEPSIE PUBLIC SCHOOL TEACHERS' ASSOCIATION
40 Garden Street, Suite 207
Poughkeepsie, New York 12601
officesecretary@ppsta.org
Office 845.471.33 Fax 845.471.6793

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, Sick Bank Chair, sickbank@ppsta.org
Poughkeepsie High School
70 Forbus Street
Poughkeepsie, NY 12603

Note: The letter from your doctor should also be sent to:
Deanna Singelton
18 South Perry Street
Poughkeepsie, NY 12601

Additional information:

- **It is also recommended you submit your request 2 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 of the number of sicks days you have, contact Deana Singleton at 845-451-4900, Ext 4970**
- **The maximum number of days that can be requested from the sick bank is 30 days. If more days are needed the process needs to be repeated.**

Questions? Contact Amber Grant @ sickbank@ppsta.org

KIMBERLY POPKEN, PRESIDENT
HEIDI MURPHY, 1ST VICE PRESIDENT · HEATHER DUNCAN-CARTER, 2ND VICE PRESIDENT
KIMBERLY COLEMAN, TREASURER · JENNIFER LANGDON, SECRETARY
KIMBERLEY MESSICK, GRIEVANCE CHAIR
AFFILIATED WITH NYSUT/AFT/AFL-CIO

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REQUEST FOR WITHDRAWL OF SICK BANK DAYS

Date: ______________________

To: SICK LEAVE BANK, Pougkeepsie Public School Teachers' Association

From: _____________________________ School: ______________________

Address:____

Phone: ____

As a member enrolled in the Sick leave Bank, I find that I have used up my accumulated sick leave days and request that ___________________ days be withdrawn from the sick leave bank in my name to cover my extended illness/disability from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/disabilty.
The nature of this disability is (please be specific):

____

____

____

Member's Signature: ____

Doctor's Name: ____

Doctor's Address: ____

Doctor's Phone: ____

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Date: ______________________

To: SICK BANK, Poughkeepsie Public School Teachers' Association

I hereby certify that ______________________________ has been under my
(patient's name)

care for _______________________________________ .
(illness/disability)

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

Complete A or B.

A. _______________________ through _______________________
(start date) (end date)

B. Starting _______________________, and will be able 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 ______________

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)