

EDUCATION ADMINISTRATORS' (P-3A)
APPLICATION FOR SICK LEAVE BANK
(Article 34, Section Fourteen)
(To be completed by the Bureau of Human Resources)

Name of Applicant: _____

	YES	NO
Has applicant contributed to the Sick Leave Bank?	<input type="checkbox"/>	<input type="checkbox"/>
Has applicant completed the one-year working test period in the Bargaining Unit?	<input type="checkbox"/>	<input type="checkbox"/>
Date of permanent appointment as a full-time member of the bargaining Unit: _____		
Has the applicant exhausted all sick leave?	<input type="checkbox"/>	<input type="checkbox"/>
The date on which all sick leave was/will be exhausted: _____		
Has applicant exhausted all but 4 weeks' vacation?	<input type="checkbox"/>	<input type="checkbox"/>
The date on which vacation was/will be exhausted: _____		
Has applicant exhausted all personal leave?	<input type="checkbox"/>	<input type="checkbox"/>
The date on which all personal leave was/will be exhausted: _____		
Is illness or injury covered by workers' compensation?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, has all workers' compensation been exhausted?	<input type="checkbox"/>	<input type="checkbox"/>
Is acceptable medical certificate supporting the entire absence on file?	<input type="checkbox"/>	<input type="checkbox"/>
Date of commencement of illness or injury for which sick leave bank benefits are being requested: _____		
Date on which applicant first returned to work after illness or injury, if applicable: _____		

Please attach the following:

- a. Copies of all medical certificates on file pertaining to the current illness or injury.
- b. Copies of applicant's attendance record applicable to this illness/injury.
- c. Copies of applicant's complete attendance record from date of employment.
- d. Copy of record of any disciplinary action for abuse of sick leave.

Completed by:

Signature

Date

**EDUCATION ADMINISTRATORS' (P-3A)
APPLICATION FOR SICK LEAVE BANK BENEFITS**

To be completed by employee and forwarded to:

DAS.BenefitsandLeavesPod4@ct.gov or faxed to **860-706-1474**

Employee Name: _____

Home Address: _____

Work Location (Agency): _____

Address: _____

The applicant hereby authorizes the Sick Leave Bank Committee to access the following:

- a. Copies of all medical certification on file pertaining to the current illness/injury.
- b. Copy of applicant's attendance record pertaining to this illness/injury.
- c. Copy of applicant's complete attendance record from date of employment.
- d. Copy of record of any disciplinary action taken for abuse of sick leave.
- e. Medical information pertaining to the current illness/injury from the applicant's physician(s) necessary to consider the application for benefits.

Applicant further certifies that he/she carefully read the Sick Leave Bank Guidelines attached hereto, has received a copy of thereof, and agrees to comply therewith. This includes submitting a new medical certificate every 60 days or as determined by the Sick Leave Bank Committee.

Signature of Applicant

Date of Application

Contact information for agency FMLA liaison:

Name: _____

Agency: _____

Telephone: _____