Patchogue Medford School District
Office for Human Resources
241 South Ocean Avenue
Patchogue, NY 11772

SICK BANK REQUEST FORM INSTRUCTIONS

1. Employee completes Sick Bank Request Form.
2. Doctor completes Sick Bank Physician's Statement.
3. Send forms to: Joey J. Cohen, Ed.D., Assistant Superintendent for Human Resources

OR

Your Sick Bank Union Representative-Form will be forwarded to Human Resources

Please Note:

The Patchogue Medford School District will only consider approval for sick bank days from the time that the official paperwork forms are received.

When requesting sick bank days for disability before a child is born, the employee's doctor **must** state the employee's anticipated delivery date on the Sick Bank Physician's Statement. Days will only be counted up to this date. Once the child is born, the employee's doctor must complete a new Sick Bank Physician's Statement indicating the delivery date. All final copies of completed forms should include original signatures and be submitted to The Office for Human Resources.

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EMPLOYEE SICK BANK REQUEST FORM

Name: _____ Unit: _____

Address:_____

_____

School or Department: _____

Home Phone: (___)_____ Alternate Contact Number: (___)_____

SICK BANK SPECIFIC REQUEST

Requested Start Date: _____ Specific End Date: _____

Total Sick Bank Days Requested: _____ Estimated Return to Work Date: _____

Attending Physician: _____

☐ I have attached my Physician's statement

Comments:_____

_____

_____ _____
Employee's Signature *Date*

_____

SICK BANK REQUEST DECISION *(for office use only)*

☐ **Request Approved:**

_____ _____
Unit Representative *Date* *District Representative* *Date*

Number of Days Approved: _____

☐ Physician's statement has been received

Dates beginning: _____ through _____

Comments:_____

☐ **Request Denied:**

_____ _____
Unit Representative *Date* *District Representative* *Date*

If denied, reason denied:

_____

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SICK BANK REQUEST PHYSICIAN STATEMENT

TO BE COMPLETED BY DISTRICT EMPLOYEE

Name: _____ Unit: _____

Address:_____

_____

School or Department: _____

Home Phone: (____)_____ Other Contact Number: (____)_____

TO BE COMPLETED BY PHYSICIAN

Brief description of disability: _____

_____

_____

If still disabled, date patient is expected to return to work: _____

Patient was under my care and unable to work: beginning _____ through _____

Physician's Name (please print): _____

Business Phone: (____)_____

Address: _____

_____

_____
Physician Signature Date

PLEASE RETURN TO PATIENT FOR SUBMISSION WITH SICK BANK REQUEST FORM

Office Use Only

_____ Date copy sent to Payroll
_____ Date copy sent to Benefits
_____ Date copy placed in Personnel File
_____ Date approval sent to employee

NOTES: