## Request to Access Centennial BOCES
## Sick Leave Bank

***Part I: To be completed by employee or representative***

Employee's Name: _____

Home Address: _____

_____

Home Phone: _____ Work Phone: _____

Position: _____ FTE: _____

Date Sick Leave Bank Membership: _____

Date illness/injury began: _____ Expected Duration: _____

Date all current sick leave will be / was exhausted: _____

Number of days requested from Sick Leave Bank: _____

Briefly describe the nature of illness / injury: _____

_____

_____

_____

_____

_____

_____

_____

Required medical records shall be attached to this request.

Employee Signature: _____ Date: _____

Program Director Signature: _____ Date: _____

Committee Chair Receipt
Signature: _____ Date: _____

Committee Disposition: _____

Executive Director: _____ Date: _____

Signature: _____ Date: _____

## PART II: Attending Physician's Statement

Employee's Name: _____ Soc Sec Number _____

Home Address: _____

_____

Home Phone: _____ Work Phone: _____

**Physician**

Name: _____ Phone: _____

Address: _____

_____

Date first consulted for this condition: _____

Briefly describe the nature, diagnosis, and treatment of illness / injury: _____

_____

_____

_____

_____

_____

_____

_____

_____

**Anticipated duration employee is unable to work due to condition.**

From: _____ Through: _____

Signature of Physician: _____ Date: _____