

Arlington Central School District

Office of Human Resources

SICK BANK FORM INSTRUCTIONS

1. Employee completes Sick Bank Request Form.
2. Doctor completes Sick Bank Physician's Statement.
3. Send forms to: Margaret Muenkel, Director of Personnel
Arlington Central School District
696 Dutchess Turnpike
Poughkeepsie, NY 12603

OR

Your Sick Bank Representative

Please Note:

The Sick Bank Committee will only consider approval for sick bank days from the time that the request was received.

When requesting sick bank days for disability before the baby is born, your doctor **must** indicate your anticipated delivery date on the Sick Bank Physician's Statement. Days will only be counted up to this date.

Once the baby is born, you must have your doctor fill out a new Sick Bank Physician's Statement indicating the delivery date and mail to: Margaret Muenkel, Director of Personnel
Arlington Central School District
696 Dutchess Turnpike
Poughkeepsie, NY 12603

**Arlington Central School District
Office of Human Resources**

SICK BANK REQUEST FORM

Name: _____ Unit: _____

Address: _____

School or Department: _____

Home Phone: _____ School Phone: _____

REQUEST

Start Date*: _____ End Date: _____

Estimated Return to Work Date: _____

Attending Physician: _____

I have attached my Physician's statement

Comments: _____

*The Sick Bank Committee will only consider approval for sick bank days from the time that the request was received.
FMLA leave will run concurrent with any disability.

Member Signature

Date

DECISION *(for office use only)*

Request Approved: _____
District Representative, Date *Unit Representative, Date*

Number of Days Approved: _____ A Physician's statement has been received

Dates beginning: _____ through _____

Comments: _____

Request Denied: _____
District Representative, Date *Unit Representative, Date*

If denied, reason denied: _____

- ___ copy to Payroll (B. Adamiak)
- ___ copy to Benefits (D. Stewart)
- ___ copy to Attendance (M. Miench)
- ___ approval sent to member's home

**Arlington Central School District
Office of Human Resources**

SICK BANK PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PATIENT

Name: _____ Unit: _____

Address: _____

School or Department: _____

Home Phone: _____ School Phone: _____

Member Signature

Date

TO BE COMPLETED BY PHYSICIAN

Brief description of disability - if applicable, indicate due date and/or delivery date (layman's terms please): _____

If pregnant, state anticipated delivery date: _____

If still disabled, date patient should be able 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