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

<u>Please Note</u>:

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***
___ ***copy to Benefits***
___ ***copy to Attendance***
___ ***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