JCAESP/AFSCME LOCAL 4011 SICK LEAVE BANK
APPLICATION FOR DAYS

Employee Name: _____
(Please print)

Job Title: _____

Location: _____

Employee ID# _____ Hire Date: _____

Date:

Please complete all information and sign and date form.

ILLNESS: *Explain illness & date illness first occurred*

_____

_____

_____

_____

MEDICAL DOCUMENTATION: *Name of attending licensed Physician(s)* **(Attach medical documentation from licensed Physician)**

_____ *Phone:*

_____ *Phone:*

Hospital *Date entered*:

_____ *Date discharged:*

ACCIDENT *Was disability/illness caused by an accident?* Yes _____
No _____

Date of Accident _____

Was this accident work related? Yes _____
No _____

Describe accident

_____

_____

_____

State medical problems resulting from accident

_____

_____

(Please complete other side.)

WORKERS' COMPENSATION

Is there possible Workers' Compensation liability?

Yes _____

No _____

DAYS

Number of sick days you are applying for on this application _____

Last day worked _____

Date licensed Physician will release you to return to work _____

Personal days left _____

Sick days left _____

Vacation days left _____

I hereby certify that all of the information provided to the JCAESP/AFSCME LOCAL 4011 Sick Leave Bank Committee on this application to be true, and complete to the best of my knowledge. I have attached medical documentation from a licensed Physician.

Employee Signature _____

Date _____

To be completed by JCAESP/AFSCME Sick Leave Bank Committee

Total days previously granted _____

Days granted for this application _____

Date _____

Committee Signature _____

Return completed form to:

JCAESP/AFSCME Local 4011
Attn: Sonya Jones, Sick Bank Chair
4315 Preston Hwy, Suite 101
Louisville, KY. 40213

08/2017