



Niskayuna Teachers Association Sick Bank Utilization Request Form

Employee Full Name _____

Building _____

Date _____

1. Please describe the nature of the illness/disability (if due to an accident, provide date, time, place and circumstances of accident). Please attach physician note/orders.

2. First day of proposed sick bank usage _____

3. Name of physician _____

4. Physician telephone number _____

** Sick leave bank use stops upon the first day of eligibility under the district's long-term disability insurance plan or upon the first day of availability for work according to a signed, dated doctor's note.

I certify that the above information is correct, to the best of my knowledge.

Employee signature _____ Date _____

Office Use Only

Total # of available sick days: _____

Dates of eight work day unpaid waiting period: _____

Date of contact with physician: _____

Date of correspondence to employee regarding status: _____