City of Providence
Sick Leave Bank Request Form

Date of Application: _____

Name: _____

Mailing Address: _____
Street City/State/Zip

_____ _____ _____
Contact Phone Number **Department** **Position**

Eligible employees are entitled under the City's NU Sick Leave Bank Time Donation Policy a maximum of thirty (30) days of paid leave for certain medical emergencies or major disasters once all accumulated sick leave is exhausted. Submit this request form to the Chief People Officer at least thirty (30) days before the leave is to commence, when practicable.

For determination of eligibility, please answer each of the following questions.

- Is this your first claim for this particular condition? _____
- Have you used the Sick Leave Bank before? _____
- What is the date at which all of your accrued sick leave days will be exhausted? _____
- Have you attached to this application a signed STATEMENT OF PHYSICIAN verifying this condition? _____
- Is your claim for elective/cosmetic surgery which could safely be scheduled during a non-work period? _____

In addition to the statement provided by my personal physician, I also agree to submit to an examination by a physician(s) of the City's choice, if requested to do so.

Dates of Sick Leave Requested
I request leave from _____ to _____
Total Number of hours of Sick Leave Bank leave that I request is (limit 210) _____

Employee Statement
I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to notify my supervisor within two days with updated leave information and I will submit an updated Physician Statement to the Sick Leave Bank Administrator.

_____ _____
Employee Signature Date

_____
Sick Leave Bank Administrator Signature (if employee unable to sign)

TO BE COMPLETED BY THE DEPARTMENT OF PEOPLE AND CULTURE

Prior Sick Leave Bank requests confirmed: _____

Leave is: Approved Denied for the following reason(s): _____
_____
_____

_____
Chief People Officer (or designee) Signature Date

City of Providence
Medical Certification Form/Statement of Physician for Sick Leave Bank
(To be submitted with Sick Leave Bank Request Form)

Employee Name: _____
Last First M.I.

Address: _____
Street City/State Zip

AUTHORIZATION TO REALEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment for the purpose of approval by the SICK LEAVE BANK.

_____ _____
Patient Signature Date

To be completed by treating physician: Briefly describe the patient's illness (in layman's language):

_____

_____

_____

_____

_____

Patient was/is under my care and unable to work from _____ through _____
(use specific dates)

Physician's Name: _____ _____ Date: _____

Address: _____ Phone: _____
Street City/State Zip

_____
Physician's Signature

Return Statement of Physician to:
Human Resources Department
City of Providence
25 Dorrance Street
Providence, RI 02903
hr@providenceri.gov
FAX: 401.273.9510

City of Providence
Sick Leave Bank Donation and Consent Form

Employee Name: _____
Last First M.I.

Address: _____
Street City/State Zip

AUTHORIZATION TO TRANSFER ACCRUED TIME

I hereby authorize and consent to the City of Providence transferring _____ hours (limit 70) of accrued sick/personal time from my existing accrual balance to the City's Sick Leave Bank. I understand that I will not be notified of the identity of any recipient of donated time. I also understand that any tax consequences as a result of this donation shall be mine and mine alone.

_____ _____
Employee Signature Date

Return to:

Human Resources Department
City of Providence
25 Dorrance Street
Providence, RI 02903
hr@providenceri.gov
FAX: 401.273.9510