

PAT SICK LEAVE BANK APPLICATION FORM

Name _____ Employee ID: _____

Address _____ Phone: _____

Work Site _____ Position Title: _____

Emergency Contact Name/Phone: _____

Attending Health Care Provider Name/Facility: _____

I am requesting _____ days of sick leave bank (Not to be less than 5 days or more than 20 days)

Answer the following:

| | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 1. I anticipate exhausting all applicable paid leave balances | % | % |
| 2. I have an extended/recurring illness/injury | % | % |
| 3. I am under a physician's care | % | % |
| 4. My illness/injury is work related | % | % |
| 5. I agree to not receive disability benefits while covered by sick leave bank hours | % | % |

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

(Signature of Employee or Guardian)

(Date)

Next Steps:

1. Submit your request to: PPS Human Resources 501 N Dixon St. Portland, OR 97227, Fax 503-916-3107, or e-mail leave@pps.net
2. Applications for sick bank are considered for approved leave and require a medical certification from your provider.

Approved: Maximum hours granted _____ (unused hours are returned to the bank)

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