University Benefits Office
395 Hudson Street
New York, New York 10014
Tel: 646-313-8230
Fax: 646-313-8888

Application to Receive Dedicated Annual/Sick Leave for Full-time Employees

This application is to be completed by a full-time employee employed on an annual salary basis with at least 2 years of continuous full-time service with the University, who believes he/she is eligible to receive donated annual/sick leave through the Dedicated Sick Leave Program.

To Be Completed By Employee

Name of Employee: _____
Home Address: _____
Employee ID No.:* _____
Title: _____
College and Department: _____
CUNY Start Date: _____

1. Is your illness or injury job related? ☐Yes ☐No

2. How many consecutive working days have you been absent from work due to your present illness or injury? State the last day you were at work.
   Days Absent: _____ Last Date Worked: _____

3. Have you applied for a sick leave advance from your college and/or for supplemental income benefits from your union for your present illness? ☐Yes ☐No
   If yes, please specify:_____

4. Have you exhausted all of your annual leave, sick leave, compensatory time balances, and sick leave advancements, to the extent applicable? ☐Yes ☐No
   If no, please indicate the number of days/hours of leave remaining.
   Annual Leave: _____
   Sick Leave: _____
   Compensatory Time: _____
   Sick Leave Advancements:_____

5. Taking into account all of your annual leave, sick leave, compensatory time, and sick leave advancements, to the extent applicable, state the last date for which you will be or were entitled to paid leave. Last date of leave entitlement: _____

6. Please indicate that you have attached documentation from your physician stating the nature and severity of your illness or injury and the projected period of your absence from work by checking the box below.
   ☐ Documentation Attached

I hereby authorize my college to accept donations of leave on my behalf with the understanding that every reasonable effort will be made by the college to maintain the confidentiality of my medical information.

_____
* If you don't know your Employee ID No., please contact the College Office of Human Resources.

I hereby authorize the College Office of Human Resources or physician retained by the College to contact my personal physician to seek clarification or additional information concerning the medical documentation submitted herewith. I also agree to submit to an examination by a physician retained by the College, if deemed necessary. I understand that Dedicated Sick Leave may be approved by the College Office of Human Resources in increments not to exceed two (2) months. Should I need more than two (2) months of Dedicated Sick Leave, I understand that I will be required to submit additional medical documentation for each subsequent two (2) month period, up to a maximum of 120 days or six (6) months of paid leave, whichever is greater.

Employee Signature: _____ Date: _____

To Be Completed By The College Human Resources Director

Date Application Received: _____

Please note that this application is to be returned to the employee within five (5) working days of receipt by the College Office of Human Resources.

☐ I have reviewed the employee's application and certify that all the answers herein are accurate when compared with the personnel and payroll records of this College.

☐ Based upon the medical documentation provided, the employee is determined to be eligible, or will shortly be eligible, to receive a sick leave donation under the Dedicated Sick Leave Program for Full-time Employees.

The employee is ineligible to receive a sick leave donation because:

☐ He/she does not meet the two (2) year continuous full-time CUNY service requirement.

☐ He/she failed to submit satisfactory medical documentation establishing a qualifying non-work related illness or injury.

☐ He/she failed to exhaust leave entitlements.

☐ He/she failed to reimburse union short-term or long-term disability benefits.

☐ (Other)_____.

If your request to receive sick leave donations has been denied, you may appeal this determination within fifteen (15) working days from the date of receipt of the denial, by writing to CUNY's Appeals Panel, in care of the University Benefits Office, 395 Hudson Street, New York, New York 10014. You should include any additional medical documentation you may have for review by CUNY's Appeals Panel.

Signature of the College Human Resources Director: _____ Date: _____