



University Benefits Office
 535 East 80th Street
 New York, New York 10075
 Tel.: 212-794-5342
 Fax: 212-794-5587

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, 535 East 80th Street, New York, New York 10075. 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: _____