



P.A.T. 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:

Yes No

- 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 will 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. Attach completed Certification of Health Care Provider form
- 2. Attach completed PPS Application for Leave of Absence
- 3. Submit your request to: PPS Human Resources 501 N Dixon St. Portland, OR 97227, Fax 503-913-3107, or e-mail jobenson@pps.net

<input type="checkbox"/>	Approved: Maximum hours granted _____ (unused hours are returned to the bank)	
<input type="checkbox"/>	Denied: Reason _____	
_____ Human Resources Department		_____ Date
_____ PAT Representative		_____ Date