



### PFSP 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 have been employed by the District for 2 years or more	<input type="checkbox"/>	<input type="checkbox"/>
2. I anticipate exhausting all applicable paid leave balances	<input type="checkbox"/>	<input type="checkbox"/>
3. I have an extended/recurring illness/injury	<input type="checkbox"/>	<input type="checkbox"/>
4. I am under a physician's care	<input type="checkbox"/>	<input type="checkbox"/>
5. My illness/injury is work related	<input type="checkbox"/>	<input type="checkbox"/>
6. I will not receive disability benefits while covered by sick leave bank hours	<input type="checkbox"/>	<input type="checkbox"/>

*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](mailto:leave@pps.net)
2. Applications for sick bank are considered for approved leave and require a medical certification from your provider.

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