SCHENECTADY COUNTY APPLICATION FOR EXTENDED SICK LEAVE BENEFITS

PART I: **TO BE COMPLETED BY EMPLOYEE. PLEASE PRINT OR TYPE**

Name _____ SS# _____
Job Title _____ Dept _____
Address _____
Telephone (H) _____ (W) _____
My injury/condition was caused by or arose from the use or operation of a motor vehicle. Yes _____ No _____
State **how, when and where** injury/conditions occurred. _____
_____
State name(s) of witness(es)_____
I last worked on _____
I have received Extended Sick Benefits for another period(s) within the 52 weeks immediately **before** my present disability began. Yes _____ No _____

I hereby claim extended sick leave benefits and certify that for the period covered by this claim, I was unable to perform my usual duties; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge, true and complete. **NOTE: False statements made herein are punishable as a class A misdemeanor pursuant to Section 210.45 of the New York State Penal Law.**

Signed _____ Dated _____

Witness _____ Dated _____

PART II: **TO BE COMPLETED BY ATTENDING PHYSICIAN OR CHIROPRACTOR. ALL ITEMS MUST BE COMPLETED. PLEASE PRINT OR TYPE.**

Employee's Name _____ Age _____ M _____ F _____
Condition for which treatment was sought: _____
_____
_____
Diagnosis: _____
In your opinion, does this condition prevent the employee from performing his/her usual duties? Yes ___ No__
Explain: _____
_____
Employee's Symptoms _____
Objective Findings _____
Employee Hospitalized? Yes _____ No _____ From _____ To _____
Surgery Indicated? Yes _____ No _____ From _____ To _____
Enter dates for the following:

	Month	Day	Year
Date you first treated this employee for this condition……	_____	_____	_____
Date of employee's most recent treatment for this condition……..	_____	_____	_____
Date this employee was first unable to work because of this condition…..	_____	_____	_____
Approximate date employee will be able to perform usual duties (please estimate)……	_____	_____	_____

In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? Yes _____ No _____ Explain: _____
_____

NOTE: False statements made herein are punishable as a Class A Misdemeanor pursuant to Section 210.45 of the New York State Penal Law. In addition, disability claims relating to an employee whose salary is funded, in whole or in part by Federal Funds, may be subject to audit by the US Department of Labor.

I hereby certify that the above named employee is/was unable to perform his/her usual duties during the above stated period because of a disabling medical/physical condition.

_____ _____

Signature of Physician Date

_____ _____

Physician's Name (Please Print) Telephone

_____

Office Address

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CIVIL SERVICE APPROVAL

_____ 1st Request Effective Date _____ Date Processed _____

_____ 2nd Request College President Approval _____ Personnel Approval _____