University of Massachusetts Amherst

Office of Human Resources

Dear USA/MTA Sick Leave Bank Member,

Thank you for your interest in the USA/MTA Sick Leave Bank. The Bank was established to maintain income for USA/MTA Sick Leave Bank members who are absent more than five (5) days due to a non-work-related illness where there is a reasonable expectation that the member will return to their job.

If you are out of work for five or more days:

1. You must submit a request for leave to your department. Approval of this request secures your job and benefits while you are out of work. Instructions on how to apply for leave are attached (Employee's Family/Medical Leave Request Checklist) with the form that must be completed by your health care provider (Certification of Health Care Provider).

2. While on a leave approved by your department, you may secure income using your accrued sick, personal, compensatory time, and vacation time. You may also apply to the USA/MTA Sick Leave Bank for income replacement.

USA/MTA Bargaining Agreement Article 10 / Sick Leave Bank states that, if approved, a member may draw upon the Bank five (5) working days after the exhaustion of all sick leave, personal leave, compensatory time, and all but ten days of accrued vacation leave. The Sick Leave Bank Committee can provide income security once these criteria are met. A USA/MTA Sick Leave Bank application is enclosed for your consideration.

To apply for income security from the USA/MTA Sick Leave Bank, please:

- complete Section One of the application,
- have your health care provider complete Section Two,
- have your supervisor complete Section Three, and
- return the application to Human Resources:
  - via mail: University of Massachusetts Amherst, Human Resources, 325 Whitmore Administration Building, Amherst, MA 01003-9313
  - via facsimile: 413.545.0483
  - in person at the Human Resources Information Center, room 325 Whitmore Administration Building, open Monday-Friday, 8:30am-5:00pm.

Please contact me at rrgrzych@admin.umass.edu or (413) 545-1473 with questions about the process.

Sincerely,
Randy Grzych
On behalf of the USA/MTA Sick Leave Bank

University of Massachusetts Amherst

USA/MTA SICK LEAVE BANK APPLICATION

USA / MTA

SECTION ONE: EMPLOYEE INFORMATION
(To be completed by the applicant - Page 1 of 2)

The Sick Leave Bank is intended to be used for short-term and non-work related disabilities, where the employee has a reasonable expectation of returning to consistently perform the job from which he/she became disabled. It is not intended as a substitute for, supplement to, other income sources (e.g. long-term disability).

Name _____ Employee ID# _____

Home Address _____

Home Telephone # _____ Work Telephone # _____

Email Address _____

Job Title _____ Department _____

Supervisor's Name _____

Telephone # _____

Email Address _____

Department Time and Attendance Keeper _____

Telephone # _____

Email Address _____

Last Day Worked _____ Expected Date of Return to Current Position _____

Nature of Illness or Injury: Please describe the illness or injury for which you are requesting time from the Sick Leave Bank. How does the illness or injury prevent you from performing your job?

University of Massachusetts Amherst

USA/MTA SICK LEAVE BANK APPLICATION

USA / MTA

SECTION ONE: EMPLOYEE INFORMATION
(To be completed by the applicant - Page 2 of 2)

OTHER INSURANCE (<u>This does NOT include the Sick Leave Bank</u>)

Do you have insurance which may cover income replacement for this illness/injury? ☐ Yes ☐ No

☐ Short-term disability policy _____
(please specify: USA/MTA, other)

☐ Long-term disability policy _____
(please specify: USA/MTA, GIC, other)

☐ Other insurance _____
(e.g. auto, homeowners. Please specify company name)

Have you applied for income replacement? ☐ *Yes ☐ No

*If yes, please specify: _____

NOTE: If you may be covered by insurance other than USA/MTA or GIC, please provide a document / letter from the insurance company outlining the waiting period and level of income replacement available.

I agree to notify the Committee prior to application for income replacement from another source for the same illness/injury.

I hereby certify that the information I provided in Section One is true and accurate.

Signature: _____ Date: _____

University of Massachusetts Amherst

USA/MTA SICK LEAVE BANK APPLICATION

USA / MTA

SECTION TWO: MEDICAL INFORMATION - <u>to be completed by physician</u>

Please answer the following questions as completely as possible. Attach additional sheets as necessary.

Patient's name: _____

1. General statement of patient's condition, diagnosis and date of onset: _____

_____

_____

2. How long have you been treating this patient for this condition (include dates of first and most recent visits)?

_____

_____

3. Please describe your treatment plan and prognosis for this patient: _____

_____

_____

_____

4. Do you believe the patient will be able to perform the duties of their current position in the future? ☐ **Yes** ☐ **No**

If **<u>yes</u>**, specify when you anticipate the patient will be able to return to work and perform the duties of their current position: _____

If **<u>yes</u>,** and you are unable to determine a return to work date at this time, when will you be able to provide a return to work date: _____

5. Do you anticipate the patient will be able to return to work earlier on a modified work schedule? ☐ **Yes** ☐ **No**

If **<u>yes</u>**, please specify the date on which the employee can return with modifications: _____

Required Work Modifications: _____

_____

_____

Specify the date when the employee will be able to return to work <u>without</u> modifications: _____

6. I hereby certify that I have examined the above-named patient and that the information provided is true based upon my knowledge and belief.

Signature of Physician _____ Date _____

7. Please **print** the following information:

Name of Physician: _____ Registration Number: _____

Address: _____

Telephone Number: _____ Specialty: _____

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USA/MTA SICK LEAVE BANK APPLICATION

USA / MTA

SECTION THREE: SUPERVISORY CONFIRMATION
(To be completed by applicant's supervisor)

I have approved _____ for up to _____ hours of leave time per week
(employee name)

from _____ until _____ due to his/her own illness.
(date) (date)

If the leave request is part-time, the employee and I have agreed to **the attached work schedule**, which meets both the needs of the department and the physician's recommendations.

Based on the information available to me, this leave does not result from a work-related illness or injury.

_____ _____
Supervisor's Signature Date

_____ _____
Supervisor's Name (printed) Campus Address

_____ _____
Campus Telephone Number Campus Email Address

PLEASE NOTE: THAT WHEN AN EMPLOYEE WILL BE OUT OF WORK DUE TO A MEDICAL ISSUE, THE EMPLOYEE AND HIS/HER SUPERVISOR MUST FOLLOW THE UNIVERSITY'S LEAVE APPLICATION AND APPROVAL PROCESS. CORRESPONDING SUPERVISORY AND EMPLOYEE CHECKLISTS ARE ATTACHED. PLEASE CONTACT THE USA/MTA SICK LEAVE BANK ADMINISTRATOR IN HUMAN RESOURCES WITH QUESTIONS AND FOR ASSISTANCE.