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 rgrzych@admin.umass.edu or (413) 545-1473 with questions about the process.

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Employee ID#</th>
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<tbody>
<tr>
<td>Home Address</td>
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<tr>
<td>Home Telephone #</td>
<td>Work Telephone #</td>
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<tr>
<td>Email Address</td>
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<td>Job Title</td>
<td>Department</td>
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<tr>
<td>Supervisor’s Name</td>
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<td>Telephone #</td>
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<td>Department Time and Attendance Keeper</td>
<td></td>
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<tr>
<td>Telephone #</td>
<td>Email Address</td>
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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?

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
OTHER INSURANCE (This does NOT include the Sick Leave Bank)

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: ___________________________
SECTION TWO: MEDICAL INFORMATION - to be completed by physician

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 yes, specify when you anticipate the patient will be able to return to work and perform the duties of
   their current position: ________________________________________________________________
   If yes, 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 yes, 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 without 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: ____________________________

USA/MTA Sick Leave Bank  •  contact: Human Resources  •  phone (413) 545-1396  •  fax (413) 545-0483
Thank you for taking the time to complete this form.
USA/MTA Sick Leave Bank 

APPLICATION

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.