CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND

APPLICATION FOR DISABILITY PAYMENTS

GENERAL INSTRUCTIONS FOR SICK LEAVE CREDITS

For the Court Attorney Applicant:

Answer all questions on this two page form. If the question is not applicable, put N/A.

1. Print or Type all your answers.
2. Attach a copy of any doctor's notes or medical documentation relevant to your claim
3. Have your physician complete the attached Certificate of Attending Physician. Please remember to sign the release on the Certificate of Attending Physician before delivering it to her/him.

Forward your application request and the attachments directly to:

CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE
CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK
WELFARE TRUST FUND
c/o Administrative Services Only, Inc
303 Merrick Road, Suite 300
Lynbrook, NY 11563-9010

If you have any questions regarding your application, please call the CALA Welfare Trust Fund Office at (800) 537-1238.

Court Attorney's Name:_____ Title:_____

Court Attorney's Work Location (Court/Judicial District/Address)

Home Phone No.	Date of Birth	Social Security No. XXX-XX-☐☐☐☐
Home Address		
Is Illness/Injury/disability Due to Occupational Cause?		☐ Yes ☐ No
Is illness/disability covered by Workers' Compensation or No Fault Insurance?		☐ Yes ☐ No
Did illness/injury/disability occur while you were on active duty in any Military,Naval or Air Force of Any County?		☐ Yes ☐ No

Name of Hospital Where Confined, If Any.		Telephone Number	Date(s) of Confinement
Address	City	St	Zip
Name of Attending Physician		Telephone Number	Date of First Treatment
Address	City	St	Zip

See 2nd Page

To all physicians, hospitals, clinics, dispensaries, sanatoriums, druggists, and all other agencies (including insurance companies,Blue Cross-Blue Shield). You are authorized to permit The Fund Administrator or any of the Trustees of the City Wide Association of Law Assistants of the Civil Criminal and Family Courts in the City of New York Welfare Trust Fund or its representatives to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions and medical expenses. Such information may be used to the extent deemed necessary by the Fund Administrator or the Board of Trustees to determine the validity of this disability request.

Signature:_____ Date:_____.

What is the Nature of Your Illness/Injury/Disability? If Injury, Please Indicate Date of Injury and Attach a Copy of the Incident Report (if available)	
Have You Returned to Work?	☐ No ☐ Yes
If So, On What Date?	
If Not, How Long Do You Expect To Be Absent From Work Due To the Illness/Injury/Disability?	
What Is Your Current Sick Leave Balance?	_____ Hours _____ Minutes
What is Your Current Annual Leave Balance?	_____ Hours _____ Minutes
What is Your Current Compensatory Time Balance?	_____ Hours _____ Minutes
The Above Balances are Based On The Time Sheets for the Period:	_____ To _____
Do You Have Any Other Full or Part-Time Employment?	☐ Yes ☐ No
If Yes, Please Indicate Name and Address of Employer	

I certify that the above statements are correct and the information furnished by me in support of this application is complete, true and correct:

_____ _____

Applicant's Signature Date

YOU MUST ATTACHA COPY OF THE CERTIFICATION FROM THE STATE CALA JOINT SICK LEAVE BANK LABOR/MANAGEMENT COMMITTEE THAT YOUR SICK LEAVE BANK ENTITLEMENT HAS BEEN EXHAUSED. THAT CERTIFICATION MAY BE OBTAINED BY WRITING TO:

Deputy Director for Employee Relations
Office of Court Administration
25 Beaver St
New York, NY 10004

CERTIFICATE OF ATTENDING PHYSICIAN

FOR DISABILITY BENEFITS FROM THE CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND

NOTICE TO PHYSICIAN:

This Certificate is being submitted by your patient in support of a request for disability benefits. In order to be eligible, a Court Attorney must have been necessarily absent from work on a full-time basis due to an illness, injury, or disability.

AN APPLICANT'S REQUEST WILL NOT BE PROCESSED UNTIL SATISFACTORY MEDICAL DOCUMENTATION SUPPORITN THE NEED FOR HER/HIS ABSENCES IS RECEIVED. YOUR COOPERATION IN PROVIDIN A DETAILED EXPLANATION OF THE COURT ATTORNEY'S CONDITION, TREATMENT AND PROGNOSIS FOR RECOVERY WILL AID IN PROMT PROCESSING OF THE COURT ATTORNEY'S REQUEST.

PLEASE PRINT OR TYPE THE INFORMATION REQUESTED

1. Patient's Name		
2. Nature of Illness, Injury, or disability		
3. If maternity,	**Estimated date of delivery**	**Type**
4. Date of initial and subsequent treatment for this illness, injury, or disability		
5. Describe nature and extent of illness, injury, or disability, when examined and, if applicable, any change or condition since last report		
6. Is the patient able to perform work of any kind? ☐ **No** ☐ **Yes**		
7. If able to perform some work, is the court attorney unable to perform any one or more of the duties of her/his job (see attached title standard)? If yes, list the specific duties that the court attorney is UNABLE to perform:		
8. If different from 7, state probable dte that court attorney will be able to perform all of the duties of her/his postions	**Date**	
9. If neither 6 nor 7 applies, it it necessary fo the court attorney to be absent from work for treatment	☐ **No** ☐ **Yes**	
10. Remarks		

Print or Type Name of Physician	**Physician's Signature**			**Date**
Address	**City**	**State**	**Zip**	**Telephone**

APPLICANT'S RELEASE AUTHORIZATION:
I HEREBY AUTHORIZE ANY PHYSICIAN OR SURGEON TO RELESE ANY INFORMATION REQUESTED WITH RESPECT TO THIS APPLICATION

APPLICANT'S SIGNATURE_____ **DATE:**_____