CIVIL SERVICE PERSONNEL ASSOC., INC.
720 Wolf Ledges #203
Akron, Ohio 44311-1553
(330) 434-2772

Time Bank Process

In order to apply for time bank, please complete the following:

1) Complete the HIPPA form & return to Michele Simon in Employee Records
2) Complete the "Request for Time Bank" form
3) Obtain a letter from your doctor (on letterhead) that lists the diagnosis and the time period needed off
4) Return the "Request for Time Bank" form and letter from your doctor to:

   Megan Prunty, Benefits Officer
   Civil Service Personnel Association, Inc.
   720 Wolf Ledges Pky, Suite #203
   Akron, OH 44311
   mprunty@cspaunion.com

Time Bank Rules

The Time Bank Committee will consider all requests for Time Bank Hours. The Committee will consist of the following:

1. CSPA Benefits Officer (or designee)
2. Deputy Mayor of Labor Relations or his designee
3. Two (2) CSPA Executive Board Members
4. The Steward of the affected member

Before fifteen (15) days of using all of their accumulated leave time, (sick leave, compensatory time, annual leave and personal days), the member shall submit a written request to the CSPA Benefits Officer for Time Bank Hours. The member applying for the Time Bank hours will receive a form authorizing release of their past leave records from the City of Akron's payroll clerk. The completed form must be returned before the committee will consider the request.

The following information is reviewed and evaluated by the Time Bank Committee in considering a request for Time Bank hours:
1. Previous sick leave usage. The Committee carefully reviews the documentation provided by the City of Akron payroll clerk. A Time Bank request may be denied if the committee determines the applicant has demonstrated a history of sick leave abuse. For Time Bank Committee purposes, sick leave abuse is characterized by any one or a combination of the following:

a) A continuous pattern of sporadic one and two day absences
b) A pattern of absence where time is regularly taken off in relationship to:

– Regular days off
– Holidays; Weekends
– Vacation time
– Compensatory time

c) The employee earns a day, then uses a day
d) The absence falls on the same day of the week
e) The absence falls either at the beginning or the end of the month

2. Supporting documentation supplied by a physician or if applicable physicians.

3. Other documentation or relative information.

The decision of the Time Bank Committee, issued in writing is final. The length of time available to any member through the Time Bank is three (3) calendar months, however under exceptional circumstances a member may apply for one (1) extension, if his/her physician will assure the Committee the at the end of the extension the member will be sufficiently recovered to return to active duty.

For further information consult rules in this document, not references.

HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Provider or Plan Information:		
Name:	Address:	
Telephone Number:	Fax Number:	E-mail:

Authorization for Provider/Plan to Disclose Protected Health Information to The City of Akron

I request and authorize you to disclose Protected Health Information from my medical or claims records to the City of Akron necessary to respond to the following purpose(s):

- ☐ Medical Certification in connection for my FMLA request
- ☐ Disability Claim
- ☐ To substantiate absence due to illness or injury ("sick note")
- ☐ Return to work, fitness for duty, reasonable accommodation
- ☐ Release of employment-related test results
- ☐ Assistance in submitting, processing, understanding a benefits claim
- ☒ Other: CIVIL SERVICE PERSONNEL ASSOCIATION (ATTENDANCE RECORD ONLY)

Disclosure of my Protected Health Information responsive to my request may be made by:

- ☐ Individual Authorizing Disclosure (or Personal Representative) will pick up.
- ☐ May be mailed to _____
- ☐ May be faxed or e-mailed to _____
- ☐ May be discussed verbally with _____

Expiration and Revocation of this Authorization

This Authorization will expire on:

- ☐ Date _____
- ☐ Upon the Disclosure of the Requested and Authorized Protected Health Information
- ☐ My return to work
- ☐ Final adjudication of my claim
- ☐ Other _____

I understand I may revoke this Authorization in writing at any time. I understand you will not be responsible for having disclosed Protected Health Information in reliance of this Authorization before you receive my written revocation.

Awareness of Rights and Responsibilities

I understand that Protected Health Information disclosed according to this Authorization to the City, in its employer or plan sponsor capacity, no longer is covered by HIPAA, and may be used or further re-disclosed to non-covered entities.

I understand I have the right to inspect or copy information disclosed by this Authorization, and that I may have a copy of this signed Authorization.

_____
Name of Individual or Personal Representative

_____ _____
Date Signature

10/03

Request for Time Bank

CIVIL SERVICE PERSONNEL ASSOC., INC.
720 Wolf Ledges #203
Akron, Ohio 44311-1553
(330) 434-2772

Date:

Name:
Address:
Telephone:
Email:
Division/Classification:

Time Available

Sick: Vacation: Personal:

Comp: Holiday:

Time Requested

Start Date: End Date:

Reason for Request:

☐ HIPAA Release sent to the City (Date Sent:)

☐ Letter from Doctor on letterhead with diagnosis listed & time period needed off

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CSPA Use Only:

☐ Approved
Amount of Time Approved:

☐ Denied
Reason:

Reset Form