

**SICK PAY FUND APPEAL FORM**

*(4 PAGES)*

**The Rules of the Sick Pay Fund specify the following relating to appeals against a decision of the Council.**

- 1.1. Any disputes emanating from the Bargaining Council refusing, repudiating or partly refusing or partly repudiating any claim instituted against the SPF by a member or any dispute as to the interpretation, meaning, intention or provisions of these rules shall be resolved as follows: -
- 1.1.1 a person aggrieved by the decision of the Bargaining Council may lodge an appeal to the Management Committee (as per the prescribed Appeal Form)
  - 1.1.2 all appeals shall be lodged within 14 (fourteen) days from the date upon which the Bargaining Council decision has been made available and shall be heard by the Management Committee within 120 (one hundred and twenty) days of being lodged.
  - 1.1.3 any appeal shall be in writing and shall contain the following: -
    - 1.1.3.1 grounds of appeal; (Committee to provide guidelines)
    - 1.1.3.2 all supporting documentation which will be used in support of the appeal.
    - 1.1.3.3 any other relevant information or documentation that may assist the Management Committee to arrive at a conclusion.
  - 1.1.4 an appeal, in the sole and absolute discretion of the Management Committee, may be amplified by oral argument.
  - 1.1.5 The Management Committee's finding on appeal shall be final and binding.
  - 1.1.6 The Management Committee's finding on appeal shall be in writing and made available to the person lodging such appeal within 14 (fourteen) days from such appeal being heard.

**1. DETAILS OF APPLICANT**

As the Applicant are you:  A Working Employer  A Legal Owner  An Employee

Name and Surname: \_\_\_\_\_ ID Number: \_\_\_\_\_

Salon Name: \_\_\_\_\_ Salon number: SAL \_\_\_\_\_

Employee number: EM \_\_\_\_\_ Email address: \_\_\_\_\_  
*(where applicable)*

Tel No. Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**2. NATURE OF CLAIM**

Short Sick Leave (absences of 6 days or less )

		<i>For Office Use Only</i>	
<b>1. Medical Condition (excluding illness that qualifies for a Virus claim).</b> <b>1.1 Date on which medical condition, examination or procedure occurred.</b>  <b>1.2 Period claimed.</b>  <b>1.3 Medical Certificate Attached</b>	<i>(Insert Date)</i>  <i>(Insert dates and number of days)</i>  <i>Yes/No</i>	<b>Short Sick Leave Balance</b>	
<b>2. Virus Claim (e.g. COVID-19 claim)</b> <b>2.1 Date on which medical condition, examination or procedure occurred.</b>  <b>2.2 Period claimed.</b>  <b>2.3 Laboratory Test Results attached.</b>  <b>2.4 Medical certificate attached.</b>	<i>(Insert Date)</i>  <i>(Insert dates and number of days)</i>  <i>Yes/No</i>  <i>Yes/No</i>	<b>Short Sick Leave Balance</b> <b>Short Sick Leave Virus Balance</b>	
<b>Copy of Vaccination Card (For absence relating to vaccination)</b>	<i>Yes/No</i>		

Long Sick Leave (absences of 7 or more days)

		<i>For Office Use Only</i>	
<b>1. Medical Condition (excluding illness that qualifies for a Virus claim).</b> <b>1.1 Date on which medical condition, examination or procedure occurred.</b>  <b>1.2 Period claimed.</b>  <b>1.3 Medical Certificate Attached</b>	<i>(Insert Date)</i>  <i>(Insert dates and number of days)</i>  <i>Yes/No</i>	<b>Long Sick Leave Balance</b>	
<b>2. Virus Claim (e.g. COVID-19 claim)</b> <b>2.1 Date on which medical condition, examination or procedure occurred.</b>  <b>2.2 Period claimed.</b>  <b>2.3 Laboratory Test Results attached.</b>  <b>2.4 Medical certificate attached</b>	<i>(Insert Date)</i>  <i>(Insert dates and number of days)</i>  <i>Yes/No</i>  <i>Yes/No</i>	<b>Long Sick Leave Balance</b> <b>Long Sick Leave Virus Balance</b>	

Maternity Leave (4 months)

<b>1. Date of Birth of Child</b>	<i>Insert Date</i>		
<b>2. Period claimed.</b>	<i>Insert Dates and Period</i>		
<b>3. Previous claims for maternity leave</b>	<i>Yes/No. If yes, number of occasions</i>		
<b>4. Birth Certificate attached</b>	<i>Yes/No</i>		

**3. GROUNDS FOR APPEAL AND SUPPORTING DOCUMENTS**

Please provide the grounds for Appeal: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the documents attached to support the Appeal *(Please ensure that all the relevant documents listed in A to C are attached to this Appeal Application)* :

- A. Original Claim Form; and
- B. Attachments\*\*
- C. Correspondence between Applicant and Council
- D. \_\_\_\_\_
- E. \_\_\_\_\_
- F. \_\_\_\_\_

<b>** CHECKLIST OF DOCUMENTS</b>		<b>X</b>
<b>Sick Leave Claims</b>	Certified Medical Certificate	
	Payslip indicating deduction	
	Latest stamped bank statement	
	Certified Copy of ID	
<b>Virus Claim (COVID-19)</b>	As above for sick leave PLUS Laboratory Test Results	
(COVID-19) Vaccination-related sick leave claim	As above for sick leave PLUS vaccination card	
Absence for Vaccination (COVID-19)	Vaccination Card	
<b>Maternity Leave</b>	Certified copy of Birth Certificate	
	Certified copy of ID	
	Stamped latest Bank Statement	

I, \_\_\_\_\_ hereby confirm that the information I have provided above, is true and correct.

\_\_\_\_\_  
Applicants' signature

Signed on \_\_\_\_\_ day of \_\_\_\_\_ 202\_, at \_\_\_\_\_