

SICK LEAVE BANK APPLICATION

Fill-out this form completely, attach supporting documents from your Healthcare Provider and submit all documents to the Human Resources.

Employee Information

Name: _____ Employee ID: _____
Address: _____ Phone: _____
School/Department: _____ Position: _____

Emergency Information:

Emergency Contact Name: _____ Phone: _____

Healthcare Information:

Physician: _____
Health Care Facility: _____

Questionnaire

Please answer the following questions:

	Yes	No
1. I have been employed by the district for 2 years or more.	☐	☐
2. I anticipate exhausting all applicable paid leave balances.	☐	☐
3. I have an extended/recurring illness/injury.	☐	☐
4. I am under a physician's care.	☐	☐
5. My illness/injury is work related.	☐	☐
6. I will not receive disability benefits while covered by sick leave bank hours.	☐	☐

Request

I am requesting ____ days from the sick leave bank (not to be less than 5 days or more than 20 days).

I certify that the above information is true to the best of my knowledge.

Signature of Employee or Guardian

Date

☐ Approved
☐ Denied

Maximum hours granted ____ (unused hours are returned to the bank).
Reason: _____

Assistant Superintendent of Human Resources

Date