## SICK LEAVE BANK WITHDRAWAL FORM

DATE OF REQUEST: _____     Employee #: _____

NAME: _____SSN: _____
              *Last*           *First*          *Middle*

LOCATION: _____ Position: _____

Number of Days Absent this fiscal year prior to this occurrence:

    Sick/Personal: _____     Vacation: _____

HAVE YOU EXHAUSTED ALL OF YOUR ELIGIBLE LEAVE

DATE OF LAST DAY WORKED: _____     # DAYS REQUESTED: _____

PHYSICIAN'S NAME: _____TELEPHONE #: _____

    ADDRESS: _____

### (PHYSICIAN'S STATEMENT MUST BE ATTACHED)

 REASON FOR REQUEST: _____

_____

_____     _____
**Member's Signature**                            **Date**

Leave grants from the bank shall be in units up to 30 consecutive days with a maximum of 40 days in a year and 90 days in a lifetime. Applicants may submit request for additional days up to 30 day units. An additional application must be submitted for each request. All leave granted, but not used by the member, must be returned to the Sick Leave Bank.

### OFFICE USE ONLY

DATE REQUEST REC'D: _____     PHYSICIAN'S STATEMENT PROVIDED:

DATE MEMBERSHIP BEGAN: _____

 MEMBER'S AVAILABLE LEAVE ENDS: _____

GOVERNING BOARD MEETING DATE: _____

ORIGINAL HIRE DATE: _____

REQUEST APPROVED: _____

    MEMBER GRANTED _____ DAYS OF SICK LEAVE BANK DAYS TO BEGIN ON
    _____ AND END ON _____.
    *(Beginning Date)*              *(Ending Date)*

REQUEST DENIED: _____

 REASON DENIED: _____

_____

_____     _____
**Signature of Chairperson or Designee**                  **Date**