SICK LEAVE BANK REQUEST FORM

SECTION A – TO BE COMPLETED BY EMPLOYEE (PRINT OR TYPE)

Name _____ SS# _____

School/Department_____ Position _____

Home Address_____

Telephone: Home _____ Work _____

Last Day Worked _____ Number of SLB Days Requested _____

Accumulated to Date: Vacation _____ Sick Leave Days _____

Describe the nature of your catastrophic illness: _____

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1. The Sick Leave Bank is available to a member with a catastrophic illness or disability causing absence from work for an extended period of time.
2. The member must have been absent, due to catastrophic illness or disability, at least forty-five (45) consecutive work days immediately prior to the day use of Sick Leave Bank days begin.
3. The maximum number of days any member may receive in any school year (July 1-June 30) is fifty (50).
4. All leave granted but not used by the member will be returned to the Sick Leave Bank.
5. Physician's Name _____
   Telephone # _____
   Address _____

_____
Signature of Employee or Designee

SUBMIT ALL COPIES TO: DR. LINDA LUMPKIN

SECTION B – TO BE COMPLETED BY SICK LEAVE BANK COMMITTEE

Date Request Received _____ Physician's Statement Attached ___Y ___ N

Member's Accumulated Leave Ends/Ended _____

First Day of Work Missed for this Illness _____

Request Granted _____ Number of Days Granted from Sick Leave Bank _____

Request Denied _____ Reason Denied _____

_____
Signature of SLB Committee Officer