Sick Leave Bank Deposit Authorization

NAME: _____

TITLE: _____

SCHOOL/LOCATION: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

I do hereby voluntarily agree to contribute one (1) of my accumulated sick leave days to the Sick Leave Bank. I understand that this will qualify me to apply for using days from the Sick Leave Bank according to approved procedures. I understand that my accumulated sick leave account will be reduced by one (1) day for each day that I am required to contribute to participate as a member in the Sick Leave Bank and that I must apply to the Sick Leave Bank Usage Approval Committee to use days from the Sick Leave Bank. I understand that I still must submit the regular sick leave cards through normal channels required by the school system.

If requested, I agree to submit a completed medical certification form to the Sick Leave Bank Usage Approval Committee for verification of medical condition. I further agree that the decision of the Usage Approval Committee shall be final.

If you wish to voluntarily participate in the Sick Leave Bank, complete and return this form to the Superintendent/designee by the date specified by the Site Administrator. Employees who are hired after that date who wish to participate in the Sick Leave Bank must return this completed form to the Superintendent/designee within ten (10) working days of employment.

_____ _____

Employee's Signature ***Date***

Review/Revised:7/27/09