COFFEE COUNTY BOARD OF EDUCATION

SICK LEAVE BANK DONATION FORM
OFFICIAL MEMBERSHIP FORM

NAME_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY/STATE ZIP

SOCIAL SECURITY NUMBER_____

HOME/CELL PHONE NUMBER_____

SCHOOL OR DEPARTMENT _____

WORK PHONE NUMBER _____

DONATIONS
In accordance with Tennessee Code Annotated 49-5-801, I hereby apply for membership in the Coffee County Sick Leave Bank. Membership shall be made during the months of **August**, **September**, or **October**. The number of days to be donated shall be prescribed by the Trustees. Donations are nonrefundable and nontransferable.

As an employee of the Coffee County Board of Education who is entitled to sick leave under the provisions of Section 49-5-710, I hereby donate two (2) sick leave days from my accumulation to the Sick Leave Bank.

_____ _____
SIGNATURE OF EMPLOYEE DATE OF APPLICATION