Teacher Request for Days from the Sick Leave Bank

Physician's statement must accompany this form. Return both to Central Services

*****Please Print Legibly*****

Name: ______________________________________ **SSN**: ________________________

School/Dept: ___________________________________ **Years w/CCBOE**: _____________

Phone: __________________ **Email**: ____

Do you have disability insurance? **Yes/No** If yes, what is the current status of your application for benefits? ____

Date accumulated paid leave was, or will be, exhausted _______________________

Number of days requested from Sick Leave Bank (20 day maximum per request) ________________

Reason for request: Use the back of this form, if necessary:___________________________

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___________________________________ ______________________

Applicant's signature **Date**

- **Action Taken by Trustee Committee**: ____approved ____denied
- **Number of days approved** ____________
- **Effective from** _______________ **to** ______________

Comments: ____

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_____________________________________ ___________________

Director of Schools **Date**