

SICK LEAVE BANK WITHDRAWAL APPLICATION
(Please type or print clearly)

DATE OF REQUEST: _____

NAME: _____ EMPLOYEE ID#: _____

LOCATION: _____ POSITION: _____

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

IS THIS YOUR FIRST REQUEST FOR THIS DISABILITY? YES NO
IF NO, HOW MANY DAYS WERE PREVIOUSLY APPROVED? _____

HAVE YOU BEEN GRANTED BANK DAYS FOR ANY PRIOR DISABILITY PERIODS? YES NO
IF YES, GIVE THE DATE(S) OF GRANT(S): _____

REASON FOR THIS REQUEST: (PHYSICIAN'S STATEMENT MUST BE ATTACHED)

PHYSICIAN'S NAME: _____ PHONE #: _____

YOUR MAILING ADDRESS: _____

CITY/STATE/ZIP CODE: _____

YOUR PHONE #: _____

I HAVE READ THE POLICY GOVERNING THE OPERATION OF THE HOUSTON COUNTY SCHOOL SYSTEM SICK LEAVE BANK AND UNDERSTAND THAT THE DECISION OF THE COMMITTEE IS FINAL. I ALSO UNDERSTAND THAT, IF APPROVED, THIS GRANT IS FOR THE SPECIFIED NUMBER OF DAYS ONLY AND THAT ADDITIONAL APPLICATIONS MUST BE FILED WITH THE COMMITTEE IF ADDITIONAL BANK DAYS ARE NEEDED.

MEMBER'S SIGNATURE: _____ DATE: _____

RETURN THIS FORM TO CATHY SOLOMON IN THE BUSINESS OFFICE-8004. IF YOU HAVE ANY QUESTIONS, CALL CATHY AT 988-6189 ext. 10253.

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OFFICE USE ONLY

DATE REQUEST RECEIVED: _____ PHYSICIAN'S STATEMENT: YES NO

DATE MEMBERSHIP BEGAN: _____ ORIG. HIRE DATE: _____

MEMBER'S AVAILABLE LEAVE TERMINATES: _____

COMMITTEE MEETING DATE: _____ REQUEST APPROVED: _____

DAYS GRANTED: _____ TO BEGIN ON _____ AND END ON _____

IF DENIED, REASON: _____

COMMITTEE'S SIGNATURE: _____ DATE: _____