



Somerset Public Schools
Somerset Berkley Regional School District
All Students Achieving Excellence

STA SICK LEAVE BANK REQUEST FORM

Date of Application: _____ **Date of Hire:** _____

Name: _____ **Job Title** _____

Mailing Address: _____

Street or Box Number

City

State

Zip

(____) _____

Home Phone Number

Work Location

Personal e-mail Address

I am applying for time to be granted to me from the Sick Leave Bank. Attached is the **Doctor's Certificate and statement** from my physician and my **Family and Medical Leave Application**.

I request leave from _____ to _____.

The total number of days of Sick Leave Bank that I request is _____.

Nature of illness or Injury _____.

For determination of eligibility, please answer each of the following questions.

YES

NO

Is this your first claim for this particular situation? If no, please explain: _____

Have you used the sick bank before? If yes, number of days granted: _____, dates these sick days covered: _____

Have you exhausted all of your accrued sick/personal/vacation leave days?

Have you attached to this application a signed statement from your Physician along with the FMLA application?

Are you currently receiving disability or Workers Compensation? If yes, please explain: _____

Employee's Signature _____ **Date** _____

Submit this request to the Sick Leave Committee c/o of the Superintendent's Office. Use of the sick leave bank counts towards FMLA leave.

Approval

Request Approved ____ Yes ____ No Date _____

Comments _____