



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 Email Address

You must have exhausted all of your available sick and personal time in order to be eligible for days.

As of _____ (date) sick leave balance is _____ and personal leave balance is _____

You must submit a detailed statement from your physician and a Family and Medical Leave Application.

Use of the Sick Leave Bank counts towards FMLA.

I request leave from _____ to _____

The total number of days requested _____

Nature of illness or Injury _____

Are you a current member of the STA? _____

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

YES NO

_____ Is this your first claim for this particular situation?

_____ Have you used the sick bank before? **

_____ 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?

** Is there anything that you would like the Sick Bank Committee to know about past use of the Sick Bank?

Employee's Signature _____ Date _____

Please submit completed form to the Superintendent's Office