Troup County School System
Your Future Starts Today

SICK LEAVE BANK WITHDRAWAL APPLICATION FORM

EMPLOYEE NAME _____ EMPLOYEE #_____

MAILING ADDRESS _____

TELEPHONE NUMBER _____

DATE OF REQUEST _____ SCHOOL _____ POSITION _____

HAVE YOU EXHAUSTED ALL OF YOUR AVAILABLE LEAVE? YES _____ NO _____

DATE OF LAST DAY WORKED _____ # OF DAYS REQUESTED _____ (Not to exceed 20)

PHYSICIAN'S NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

REASON FOR REQUEST/NATURE OF ILLNESS _____

A STATEMENT FROM DOCTOR MUST BE ATTACHED. THE STATEMENT MUST INCLUDE NATURE OF ILLNESS.

Please be aware that you must be out at least fifteen (15) consecutive school days (not including weekends, holiday, etc.) in order to be eligible for Sick Bank.

I give permission for my doctor to be contacted should the Sick Leave Bank Committee have questions.

_____
EMPLOYEE/SICK BANK MEMBER SIGNATURE

* *Leave grants from the bank shall be granted in units up to 20 consecutive days to a maximum of 60 days. Applicants may submit requests for additional days up to 20 day units. An additional application must be submitted for each request along with an updated statement from physician. All leave granted, but not used by the member, must be returned to the Sick Leave Bank at the end of the calendar year.*

OFFICE USE ONLY

Date Request Received _____ Sick Bank Membership Verified _____

Physician's Statement Provided _____ Approved _____ Denied _____ Principal/Director Notified_____