

Sick Leave Bank Application

To be filled out by applicant:

Name _____

Social Security Number: _____

School/Teaching Assignment: _____

Number of days requested:

Tenured – maximum 90 days/year _____

(5 year maximum 150 days)

Non-Tenured – maximum 30 days/year _____

(5 year maximum 60 days)

Anticipated date of first usage: _____

Please **attach verification** by a licensed medical physician of the disability.

(Verification will be required after **each** thirty (30) day period.)

To be filled in by committee:

_____ Approved

_____ Denied

_____ Date

_____ Date

_____ # of days approved

_____ Beginning date

_____ Reverification from physician due _____

Signatures of Approval:

District # 61 Administrator _____

District # 61 Administrator _____

DEA Representative _____

DEA Representative _____

After Approval, Human Resources send copy to:

____ Payroll

____ Applicant

____ DEA

Failure to follow the provisions of Article X, A.7 (Sick Leave Bank) of the contract in a timely manner may cause you to be docked or jeopardize your pay.