Date of Hire:_____

Date Enrolled in Bank:_____

Division of Human Resources

SICK LEAVE BANK WITHDRAWAL APPLICATION

(Please Print)

Employee's Name:_____

Employee's I.D. No.:_____ Position:_____

Work Location:_____ Location No:_____

Home Address: _____

(Street) *(Apt. No.)*

_____

(City) *(State)* *(Zip)*

Home Phone: (____) _____ Last date you worked:_____

No. of days requested from Bank:_____ No. of hours worked per day:_____

How long have you been a member of the Sick Leave Bank? _____

The Committee may need to speak with you. Please leave a day time phone number where you can be reached during the scheduled meeting. (____) _____

INFORMATION REQUIRED TO PROCESS YOUR APPLICATION

1. Applicant must answer the questions and provide the required information in detail on the attached "Sick Leave Applicant Information Sheet" (Form PER-819.042).
2. "Physician's Statement" (Form PER-810-041) must be completed and signed by applicant's physician, describing the catastrophic condition, what kind of treatment prescribed, how long applicant will be out of work, whether he/she expects a normal recovery time, any other information that will assist the Sick Leave Bank Committee in making a decision. This form MUST be signed by applicant's physician, not an assistant.
3. Form letter from Principal/Worksite Supervisor regarding applicant's use of leave time for the previous two years. Please use attached "Principal's/Worksite Supervisor's Statement" (Form PER-819-040).

I hereby authorize any physician, hospital, clinic, pharmacy, insurance company, employer, or organization to release any and all information regarding the medical history, treatment, disability, or benefits payable for this claim only, to Alachua County Public Schools Sick Leave Bank Committee. A photo copy of this authorization shall be as valid as the original.

_____ _____

Applicant's Signature *Date Signed*