SUPERINTENDENT'S REGULATION 5-7.6 (C)

POQUOSON CITY PUBLIC SCHOOLS
500 CITY HALL AVENUE
POQUOSON, VA 23662

I HAVE REVIEWED AND UNDERSTAND THE POLICIES GOVERNING THE SICK LEAVE BANK AND WISH TO PARTICIPATE AS A MEMBER OF THE BANK

EMPLOYEE NAME	
HOME ADDRESS	
CITY / STATE	
HOME PHONE NUMBER	
SCHOOL OR OFFICE LOCATION	
POSITION HELD	
SIGNATURE	
DATE	

FOR OFFICE USE ONLY

SCHOOL YEAR	DAYS CONTRIBUTED	DAYS USED	DATE OF USE

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SICK LEAVE BANK ASSESSMENT NOTICE

AS DEFINED BY THE POLICY GOVERNING THE OPERATION OF THE SICK LEAVE BANK, A MINIMUM OF 50 DAYS MUST BE MAINTAINED FOR THE BANK TO BE OPERATIONAL. THE POLICY INDICATES THAT AN ASSESSMENT OF ONE DAY WILL BE MADE OF EACH PARTICIPATING MEMBER SHOULD THE BANK BALANCE DROP TO 50 DAYS OR LOWER.

THIS NOTICE IS TO INDICATE THAT YOU WILL BE ASSESSED ONE SICK DAY FOR CONTRIBUTION TO THE SICK LEAVE BANK ON THE LAST WORKING DAY OF THIS MONTH.

IF YOU WISH TO REQUEST THAT NO ASSESSMENT BE MADE, WHICH WILL RESULT IN THE TERMINATION OF YOUR MEMBERSHIP IN THE BANK, PLEASE COMPLETE THE INFORMATION BELOW.

PLEASE NOTE: If the "Request for Termination" is not forwarded to the finance office on or before the last working day of this month, an automatic assessment of one sick leave day will be made. Notification must be received within 15 work days of the assessment notice.

REQUEST FOR TERMINATION OF MEMBERSHIP IN SICK LEAVE BANK

I request that my membership in the Poquoson City Schools Sick Leave Bank be terminated as of

_____*(Date).*

This request is made with full understanding that any days I have contributed will remain in the Bank.

NAME: _____

DATE: _____

WORK LOCATION: _____

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APPLICATION FOR USE OF SICK LEAVE BANK

*NAME:*_____
*TELEPHONE:*_____
*SCHOOL OR OFFICE LOCATION:*_____
*REASON FOR REQUEST:*_____
_____
_____
_____
_____
_____
*DATE INCAPACITY WILL BEGIN/BEGAN:*_____
*DATE SICK LEAVE DAYS WILL TERMINATE:*_____

The employee should furnish the required physician's statement with this application.

*SIGNATURE:*_____*DATE:*_____

Please do not write below this line

ADVISORY COMMITTEE RECOMMENDATION

*APPROVED:*_____*DISAPPROVED:*_____

*Sick Leave Bank Advisory Committee Chairperson:*_____
*Advisory Committee Members Present:*_____
_____
_____
_____
_____

*COMMENTS:*_____
_____
_____

*DATE:*_____

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Physician's Statement

I hereby authorize my physician to release the information requested on this form and to provide additional information upon request of my employer.

*Signature:*_____*Date:*_____

Dear Physician:

The above named employee is requesting benefits under the provision of the Poquoson City Schools Sick Leave Bank. This program is maintained and supported by the contributions of sick leave days by individual members with the purpose of assisting an employee who is incapacitated by an illness or injury.

Please describe the nature of the illness or injury that will prevent the employee from fulfilling his/her contractual responsibilities.

_____
_____
_____
_____
_____
_____
_____

I hereby certify that the above named employee of Poquoson City Schools is totally unable to meet contractual responsibilities due to the conditions described above. The return to work date is projected to be: _____

*Physician's Signature:*_____

*Street Address:*_____

*City/State/Zip Code:*_____

*Date:*_____