GWINNETT COUNTY PUBLIC SCHOOLS

Sick Leave Bank Application

Benefits & Leave Administration • 437 Old Peachtree Road, NW, Suwanee GA 30024-2978 • Fax 678-301-6111

Name:	Employee ID #:
Employee Contact Number:	Last Day Worked:

To Be Completed by Employee

I am a member of the Sick Leave Bank, and meet the eligibility qualifications for a withdrawal, based on the criteria identified by Gwinnett County Public Schools policy and procedure. I hereby request a withdrawal from the Sick Leave Bank.

Employee Signature: _____ Date: _____

To Be Completed by the Healthcare Provider

Beginning date of disability: _____ Anticipated Return to Work Date: _____

Diagnosis: _____

Circle any applicable categories identified below that currently apply to the aforementioned diagnosis.

Prolonged hospitalization is necessary Catastrophic illness Life Threatening Not Applicable

Healthcare Provider Name (printed): _____ Phone: _____

Address: _____

Healthcare Provider Signature: _____ Date: _____

To Be Completed by the Human Resources Benefits and Leave Director

_____ I hereby certify that the above applicant does meet the eligibility qualifications to withdraw hours from the Sick Leave Bank, and I recommend that the request be granted.

Total Days Granted: _____ Effective Date: _____

_____ I hereby certify that the above applicant DOES NOT meet the eligibility qualifications to withdraw hours from the Sick Leave Bank, and I recommend that the request be denied.

Human Resources Signature: _____ Date: _____