Revised April 2025

SICK LEAVE BANK INITIAL REQUEST - LICENSED

Name _____
(please print)
Phone _____ School or Department _____
Number of days requested _____ Anticipated date of return _____

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1. I have used:
    a. All my individual accumulated sick leave.
    b. All my paid individual personal leave.
2. I have attached the following to this request form:
    a. Personal statement indicating the circumstances for which I am requesting this additional sick leave.
    b. Physician's statement indicating that I am unable to perform my assigned responsibilities due to a long-term or chronic illness or injury.
3. I authorize the Sick Leave Bank Committee to verify my date of employment, contribution to the Sick Leave Bank, paid sick leave balances and paid personal leave balances.
4. I understand that any unused sick leave days will be returned to the Sick Leave Bank.
5. I affirm that this information I have provided is accurate to the best of my knowledge.

_____ _____
Signature Date

For Committee Use Only

Date Request received _____ Date Request reviewed _____

___ Request Approved ___ Request Denied

If denied, state reason:

_____

_____

Number of days granted _____ beginning on _____

Number of days unused and returned to the Sick Leave Bank _____

Signature of Committee Chair _____