

Sick Bank Usage Request Form

Certified Staff Classified Staff

Name _____ Position _____ Building _____

Dates of Absence: _____

Number of days requested: _____

Describe briefly the nature of this absence:

A member shall be required to furnish a medical statement from a licensed physician at any time before or during the time sick bank days are requested. Please attach a statement from your physician to verify the request is within the parameters of the sick bank requirements.

Signature: _____ Date: _____

Business Office Use Only:

Confirmation of dates of absence: YES _____ NO _____ Number of sick days used: _____

Number of sick days remaining: _____ Daily rate of pay: _____

Signature: _____ Date: _____
(Corporation Treasurer)

Sick Bank Committee Use Only:

Number of days approved: _____ Number of days rejected: _____

Comments:

Signature: _____ Date: _____
(SBC Chairperson)

Appeal Board Use Only:

Number of days approved: _____ Number of days rejected: _____

Comments:

Signature: _____ Date: _____
(Appeal Board Chairperson)