Sick Leave Bank Donor Form

Name _____

School or Department _____

If you would like to participate in the Sick Leave Bank Program complete the following Section:

I, _____, agree to participate in the DeKalb County Sick Leave Bank and initially have (2) two days of my accumulated sick leave deducted from my personal accumulation and deposited to the Sick Leave Bank. I understand that donations of sick leave are nonrefundable and nontransferable, unless the Bank is dissolved. I also understand that if the number of days in the Bank is less than (20) twenty, or (1) one per member if there are more than (20) twenty members, or at any time deemed advisable, the Trustees shall assess from each member (1) one or more days of accumulated sick leave. The number of days assessed from each member shall not exceed (3) three days per assessment. If any member has no accumulated sick leave at the time of assessment, the first earned days shall be donated as they are accrued by the employee. I also understand that a member may withdraw from the Bank by written notice effective June 30 next. I am aware of the provisions of the sick leave bank and relieve the DeKalb Board of Education, the DeKalb Teachers Association, and the individual Trustees from any liability as a result of action taken by the Trustees.

If You Do Not want to participate in the Sick Leave Bank Program complete the following Section:

I, _____, do not wish to participate in the Sick Leave Bank Program.

_____ _____

Signature Date