



Sick Leave Bank Request for Days

Physician's statement must accompany this form. Return both to Central Services

Name: _____ SSN: _____

School/Department: _____ Years with CCBOE: _____

Check Employee Type: ☐ Certified ☐ Non-Certified

Phone: _____ Do you have any disability insurance? Yes No

Circle one

If yes, what is the current status of your application for benefits? _____

_____ Date accumulated leave was, or will be, exhausted

_____ Number of days requested from Bank (20 day maximum per request)

Reason for request: (use the back of this form, if necessary)

Applicant's signature _____ Date _____

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Action taken by the Trustee Committee: ☐ approved ☐ denied

Effective from: _____ to _____

Comments: _____

Director of Schools

Date