Mobile County
PUBLIC SCHOOLS

1 Magnum Pass | Mobile, Alabama 36618 | 251-221-4000 | www.mcpss.com



TEAM MCPSS,

PLEASE NOTE THAT WHEN YOU ARE READY TO RETIRE, SCHEDULING AN APPOINTMENT WITH THE DISTRICT CENTRAL OFFICE ASSURES THAT YOU RECEIVE THE SPECIALIZED ATTENTION YOU DESERVE TO ADDRESS YOUR SPECIFIC INTREST WITH REGARD TO YOUR RETIREMENT BENEFITS.

MEMBERS ARE ENCOURAGED TO ACCESS THE RSA (RETIREMENT SYSTEMS OF ALABAMA) WEBSITE TO SCHEDULE TO ATTEND A SEMINAR FOR PLANNING OR IN PREPARATION FOR RETIREMENT. CONTACT A TRS (TEACHER'S RETIREMENT SYSTEMS) COUNSELOR TO LEARN ABOUT YOUR MONTHLY BENEFIT AMOUNT.

MEMBERS SHOULD ALSO CONTACT RSA TO SPEAK WITH A PEEHIP COUNSELOR WITH REGARD TO THE INSURANCE IF YOU PLAN TO KEEP IT WHEN YOU RETIRE. 1-877-517-0020 OR WWW.RSA-AL.GOV

IT IS IMPORTANT TO COMMUNICATE YOUR DESIRE TO RETIRE UP TO 90 DAYS IN ADVANCE, BUT NO LESS THAN 30 DAYS AND SUBMIT YOUR RESIGNATION. THE DISTRICT OFFICE REQUESTS NOT LESS THAN 45 DAYS.

CONTRATULATIONS ON YOUR UPCOMING RETIREMENT!!!

I LOOK FORWARD TO ASSISTING YOU.

INGRID MIA WARD
EMPLOYEE RELATIONS - RETIREMENT DIVISION
HUMAN RESOURCES DEPARTMENT
IMWARD@MCPSS.COM
OFFICE: 251-221-4525
RECEPTIONIST: 251-221-4500

TRS OF ALABAMA

# Disability Retirement Application Packet

## Part I

If your career is cut short because of permanent disability, you may qualify for monthly disability benefits.

PART I of the Disability Retirement Application Packet and the Report of Disability Packet are required to initiate the disability retirement process. Once we receive your completed Part I forms and your Report of Disability Packet, the RSA Medical Board will meet to determine eligibility (the first Tuesday of each month). If approved for disability, the TRS will send the Retirement Application Packet Part II. **The retirement process is not complete until you have returned the RSA Retirement Benefit Option Selection form in Part II.**

### START TODAY

This document includes the following forms:

- **TRS Application for Disability Retirement**
- **PEEHIP Insurance Authorization**
- **RSA Direct Deposit Authorization**

### IMPORTANT INFORMATION

- The TRS Application for Disability Retirement must be received at least 30 days and not more than 90 days prior to the effective date of retirement.
- The Report of Disability Packet must also be received at least 30 days and not more than 90 days prior to the effective date of retirement.
- The effective date of retirement must be the first day of a month.
- It is the responsibility of the member to ensure all forms are mailed to the TRS.

### CONTACT US

Please contact Member Services at 877.517.0020 if you have any questions.

Make sure that the TRS has your current home mailing address. You can change your mailing address online at https://mso.rsa-al.gov or by completing the Address Change Notification form. Important information regarding your retirement will be mailed from time to time to your home mailing address.

## FORM INSTRUCTIONS

1. Complete the **TRS Application for Disability Retirement** in its entirety. Incomplete forms will be returned to the member for completion.
2. Complete the **PEEHIP Insurance Authorization** form. **Please do not forget to sign this form where needed.**
3. Complete the first page of the **RSA Direct Deposit Authorization** form. Send this form to your financial institution to complete the second page. This form will authorize the TRS to remit and credit your benefit directly to your bank account and eliminate the possibility of your check being lost or stolen.
4. Send the **TRS Application for Disability Retirement**, **PEEHIP Insurance Authorization**, and any other completed forms to:

   TRS
   P.O. Box 302150
   Montgomery, AL 36130-2150

Your **TRS Application for Disability Retirement** must be received by the TRS at least 30 days and not more than 90 days prior to the effective date of retirement. The effective date of retirement must be the first day of the month.

## FREQUENTLY ASKED QUESTIONS

**Q.** How do I qualify for disability retirement?

To qualify for a disability benefit, the member must meet all of the following conditions: (1) The member must have 10 years of creditable service. (2) The member must be in-service. A member is considered in-service if currently working or on official leave of absence, with or without pay, for one year, which may be extended for no more than one additional year. A member will not receive service credit for periods of leave without pay. (3) The RSA Medical Board must determine the member to be permanently incapacitated for the further performance of duty. The Medical Board bases its determination upon information provided by the member's physician. The Medical Board normally meets on the first Tuesday in each month.

**Q.** How are disability benefits calculated?

Maximum monthly disability retirement benefits are calculated identically to those for service retirement, **except** that additional credit for sick leave cannot be converted to retirement credit unless the member is also eligible for service retirement.

**Q.** What is an annual disability review?

A disability retiree will be reviewed once each year for the first five years and once every three-year period thereafter until age 60 for Tier I members and age 62 for Tier II members (age 56 for Tier II firefighters and law enforcement) to determine whether the retired member remains eligible for disability benefits.

If the Report of Disability Packet is being completed for the Annual Disability Review, the medical documentation provided by your physician must be based upon a current examination conducted within four months prior to submission of the forms to the RSA. The completed forms are to be returned to the RSA within 30 days of the initial request.

**Q.** How do I cancel my retirement application?

Should you desire to cancel your TRS Application for Disability Retirement, written notice must be given to the TRS prior to your effective date of retirement. Failure to give timely notice will result in an irrevocable application.

**Questions?**

- » Visit RSA's website at www.rsa-al.gov
- » Email TRS through the RSA website; click on the "Contact" link at the top of the page
- » Call TRS at 877.517.0020
- » Attend a TRS Retirement Preparation Seminar

TRS OF ALABAMA

# TRS Application for Disability Retirement

Teachers' Retirement System of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

**Your SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

## Your Information

Name _____
First Middle/Maiden Last

Mailing Address _____
Street or P.O. Box Apt.# City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____ PID (optional) _____

## Retirement Information

Employer_____ Employer Telephone_____

Date of Retirement _____ *(This date is always the first of a month.)*

## Beneficiary Designation

*Divorce or annulment of a marriage shall not revoke or void the designation of a spouse as beneficiary for any benefits payable by RSA.*

The beneficiary to whom I should like to receive any benefit due at my death _____

Relationship to me _____ Sex ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____

If the designated beneficiary listed above is different from that listed on my active account, make the change effective **(check one)**:

☐ Upon the submission of this signed and notarized application to the TRS.
☐ On the date of my retirement.

If you are naming multiple beneficiaries, please use the MULTIPLE BENEFICIARIES ATTACHMENT form located on our website. The DESIGNATION OF BENEFICIARY PRIOR TO RETIREMENT form **will not** be accepted for retirement purposes.

## Signature Certification

***Sign Here*** ➔ *Member*

*Please have your signature acknowledged before a Notary Public.*

**Your Signature** _____ **Date** _____

State of _____ , County of _____

I, _____ , a Notary Public, hereby certify that the above named individual whose name is signed to the foregoing document, personally appeared before me and acknowledged under oath that the statements made are true. Given under my hand this _____ day of _____ , 20 _____.

Signature of Notary Public _____

Seal

My Commission Expires _____

TRS OF ALABAMA

# TRS Application for Disability Retirement
# PEEHIP Insurance Authorization

Teachers' Retirement System of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

**Your SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

**Name** _____

## Hospital Medical Information

Members currently enrolled in PEEHIP Hospital Medical coverage, check the box which applies:
I wish to ❑ continue or ❑ cancel my PEEHIP Hospital Medical coverage.
Requested Date of Cancellation ❑ Date of Retirement ❑ End of Extra Coverage Months
I agree to have premiums deducted from my retirement check for any months that are due but were not deducted.

***Sign Here*** ➔ *Member* **Your Signature** _____ **Date** _____

## Street Address Information

The Center for Medicare and Medicaid Services (CMS) requires PEEHIP to maintain physical street addresses for all Medicare-eligible members and dependents. If you have a P.O. Box number as your mailing address on page 1 of the TRS Application For Disability Retirement form, please provide us with your street address below. **Receipt of this information is critical to ensure there are no delays in processing your medical or prescription drug claims.** Your street address will not be used as a permanent mailing address, but will be maintained in our system for informational purposes to cooperate with CMS regulations. This update will not change the address used to mail or deposit your retirement check.

Current Street Address _____

## Optional Coverage Plans

*Complete if enrolled in Dental, Vision, Indemnity, and/or Cancer coverages* **only**.

Persons who are not insured on a PEEHIP Hospital Medical plan and are only enrolled in the Optional Coverage Plans (Dental, Vision, Indemnity, and Cancer) can continue all four coverages or drop **two** Optionals at the time of your retirement. The retired state contributions will pay the premium for **two** of the Optionals without a payroll deduction for those retirement members enrolled in only the Optional Coverage Plans. If you are not currently enrolled in Optional Coverage Plans, you can only enroll during Open Enrollment.

If you are only enrolled in the Optional Coverage Plans and wish to drop down to two plans, please indicate which two plans you wish to **keep** on your date of retirement. To keep all four Optionals, mark "All." You cannot drop only one and keep three except during Open Enrollment.

❑ Dental ❑ Vision ❑ Indemnity ❑ Cancer ❑ All

I agree to have premiums deducted from my retirement check for any months that are due but were not deducted.

***Sign Here*** ➔ *Member* **Your Signature** _____ **Date** _____

## Non-Participating Universities and Vested Members Not Currently Enrolled

**Members from non-PEEHIP-participating universities and vested members applying for retirement:**
You are eligible to enroll in hospital medical insurance through PEEHIP at the time of your retirement.

PEEHIP will send you an information packet about PEEHIP and an enrollment form after the RSA receives your TRS Application for Service Retirement or your TRS Application for Disability Retirement.

Please note that you cannot enroll in PEEHIP Optional Coverage plans (dental, vision, indemnity, cancer) at the time of your retirement, and you cannot enroll dependents who are not currently covered under PEEHIP (with the exception of active university employees, who may keep their covered dependents enrolled). Optional and dependent enrollments must be completed during annual Open Enrollment.

# Report of Disability Packet

## If your career is cut short because of permanent disability, you may qualify for monthly disability benefits.

This packet contains the information and forms you need to initiate the disability retirement process. Once we receive your completed Report of Disability Packet and Disability Retirement Application Packet Part I, the RSA will send the Retirement Application Packet Part II. **The retirement process is not complete until you have returned the RSA Retirement Benefit Option Selection form in Part II.**

### START TODAY

This document includes the following forms:

» **Part A: Statement by Examining Physician**

» **Part B: Applicant Authorization**

### IMPORTANT INFORMATION

» The Statement by Examining Physician and your Disability Retirement Application Packet Part I must be received at least 30 days and not more than 90 days prior to the effective date of retirement.

» The effective date of retirement must be the first day of a month.

» It is the responsibility of the member to ensure all forms are mailed to the RSA.

### CONTACT US

Please contact Member Services at 877.517.0020 if you have any questions.

Make sure that the RSA has your current home mailing address. You can change your mailing address online at https://mso.rsa-al.gov or by completing the Address Change Notification form. Important information regarding your retirement will be mailed from time to time to your home mailing address.

Retirement Systems of Alabama
P.O. Box 302150 • Montgomery, Alabama 36130-2150 • 877.517.0020 • 334.517.7000 • www.rsa-al.gov

September 2019

## FORM INSTRUCTIONS

1. Have your physician complete the **PART A: STATEMENT BY EXAMINING PHYSICIAN** after he/she has examined you. The form must be based upon a current examination conducted within four months prior to your effective date of retirement.
2. Complete the **PART B: APPLICANT AUTHORIZATION** form. The completed and signed form will authorize your physician to provide medical documentation to the RSA.
3. Send the **PART A: STATEMENT BY EXAMINING PHYSICIAN**, and any other completed forms to:

   RSA
   P.O. Box 302150
   Montgomery, AL 36130-2150

The **STATEMENT BY EXAMINING PHYSICIAN** and your **DISABILITY RETIREMENT APPLICATION PACKET PART I** must be received at least 30 days and not more than 90 days prior to the effective date of retirement. The effective date of retirement must be the first day of a month.

## FREQUENTLY ASKED QUESTIONS

**Q.** How do I qualify for disability retirement?

To qualify for a disability benefit, the member must meet all of the following conditions: (1) The member must have 10 years of creditable service. (2) The member must be in-service. A member is considered in-service if currently working or on official leave of absence, with or without pay, for one year, which may be extended for no more than one additional year. A member will not receive service credit for periods of leave without pay. (3) The RSA Medical Board must determine the member to be permanently incapacitated for the further performance of duty. The Medical Board bases its determination upon information provided by the member's physician. The Medical Board normally meets on the first Tuesday in each month.

**Q.** How do I apply for disability retirement?

If the REPORT OF DISABILITY PACKET is being completed as verification of medical reasons for retiring on disability, it must be submitted with the DISABILITY RETIREMENT APPLICATION PACKET PART I. All packets are due to the RSA no less than 30 days and not more than 90 days before your effective date of retirement.

**Q.** How are disability benefits calculated?

Maximum monthly disability retirement benefits are calculated identically to those for service retirement, **except** that additional credit for sick leave cannot be converted to retirement credit.

**Q.** What is an annual disability review?

A disability retiree will be reviewed once each year for the first five years and once every three-year period thereafter until age 60 (age 52 for State Police) for Tier 1 Members and age 62 (age 56 for State Police and FLC) for Tier 2 Members to determine whether the retired member remains eligible for disability benefits.

If the REPORT OF DISABILITY PACKET is being completed for the Annual Disability Review, the medical documentation provided by your physician must be based upon a current examination conducted within four months prior to submission of the forms to the RSA. The completed forms are to be returned to the RSA within 30 days of the initial request.

**Q.** How do I cancel my retirement application?

Should you desire to cancel your APPLICATION FOR DISABILITY RETIREMENT, written notice must be given to the RSA prior to your effective date of retirement. Failure to give timely notice will result in an irrevocable application.

**Questions?**

- » Visit RSA's website at www.rsa-al.gov
- » Email RSA through the RSA website; click on the "Contact" link at the top of the page
- » Call RSA at 877.517.0020
- » Attend a Retirement Preparation Seminar or an individual counseling appointment

# Report of Disability Part A: Statement by Examining Physician

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

**Your SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

**Check One:** ❑ TRS ❑ ERS

## Applicant Information

*For the application to be processed, all items must be completed.*

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____ Sex ❑ Male ❑ Female

Job Classification_____ Blood Pressure_____ Height _____ Weight_____

## Physician Statement

*Medical examination must be conducted* **within four months** *prior to the effective date of retirement or annual disability review date.*

This is to certify that the above named person has been under my professional care since _____ and was last
Month/Day/Year)

examined on _____ .
Month/Day/Year

Please list this patient's job requirements as described to you:

_____

_____

_____

_____

_____

**In your professional opinion, by reason of the described condition, is the named applicant totally incapacitated for further performance of his/her duty?** ❑ Yes ❑ No

If yes, list in detail the pathophysiologic diagnoses with supporting evidence for the diagnoses that cause the disability.

_____

_____

_____

_____

_____

**In your professional opinion, is the named applicant's disability permanent?** ❑ Yes ❑ No

If yes, list the objective findings that render the applicant permanently incapacitated to perform the normal functions of his/her duty.

_____

_____

_____

_____

_____

## Report of Disability Part A: Statement by Examining Physician

*Submit completed form to the Retirement Systems of Alabama*

**Name** _____ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

### Physician Statement Continued

*Any person who makes a false statement or falsifies a record in an attempt to defraud the RSA shall be guilty of a misdemeanor, punishable by a fine up to $500 and/or imprisonment not to exceed one year.*

Please list the patient's restrictions and reason for restrictions:

In your opinion, are there reasonable accommodations that could be made by the patient's employer to allow this patient to continue his/her employment? ❑ Yes ❑ No

If yes, list possible reasonable accommodations.

Remarks and/or records that clarify or support your diagnoses and findings.

### Signature Certification

This application will not be processed until the form is completed in full and bears physician's signature.

***Sign Here →*** *Physician*

**Physician's Signature** _____ **Date** _____

Original signature is required.

Physician Name _____

Address _____

Street or P.O. Box City State ZIP Code

Telephone Number _____ Physician Specialty _____

# Disability Retirement Packet Part B: Applicant Authorization

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

**Your SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

**Check One:** ❑ TRS ❑ ERS

## Your Information

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____

## Physician Authorization

Physician Name _____

Physician Address _____
Street or P.O. Box City State ZIP Code

**Authorization for Release of Information**

I am applying for: *(check only one)*
❑ disability benefits from the Retirement Systems of Alabama (RSA)
❑ an annual disability review

## Member Authorization

I am required to obtain from my treating physician medical information to support my claim for benefits. This information will be provided to the RSA Medical Board members for the purpose of determining my eligibility for benefits. I hereby authorize the release of my medical records to the RSA. Please mail the completed REPORT OF DISABILITY PART A: STATEMENT BY EXAMINING PHYSICIAN to the RSA at the above address.

***Sign Here*** ➔ **Your Signature** _____ **Date** _____
*Member*

# RSA Direct Deposit Authorization

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

**Your SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

**Direct Deposit from System(s):** ☐ TRS ☐ ERS ☐ JRF ☐ MRS ☐ SNU ☐ PEIRAF ☐ RSA-1 *(Annual or Monthly Distribution Only)*

## Your Information

*No initials please*

*Indicate below* **Your SSN** *the system(s) from which you would like your benefit(s) direct deposited.*

Name _____
First Middle/Maiden Last

Mailing Address _____
Street or P.O. Box Apt.# City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____ PID (optional) _____

**Check One:** ☐ Retiree ☐ Beneficiary of Deceased Retiree or Member

If you are a beneficiary, please provide the following for the deceased retiree or member.

Name _____ SSN _____

## Account Holder Certification

I agree to notify the Retirement Systems of Alabama (RSA) immediately of the death of the recipient of the retirement benefits being deposited to this joint financial institution account, and to return all payments to the RSA that are deposited to this account after said death. The RSA will determine and pay any survivor benefits. The RSA is authorized to make necessary debit entries to this joint account for any credits that were made in error.

| Joint Financial Institution Account Holder(s) Name(s) | Joint Financial Institution Account Holder(s) Signature(s) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Date** _____

## Signature Certification

Each benefit payment is to be credited to my account at the financial institution specified on the reverse side of this form and such payment will be in full payment, satisfaction, and discharge of the amount then falling due and payable to me on account of such payments.

If my death occurs prior to the due date of any payment made by the RSA in compliance with this request or if adjustments are required for any credit entries to my account, I authorize the RSA to make the necessary debit entries to my account. I hereby reserve the right to revoke or cancel this request, such revocation or cancellation to take effect within 30 days of receipt of written notice by the RSA.

I authorize my payment to be sent to the financial institution named on the reverse side of this form to be deposited to the designated account.

***Sign Here →*** **Your Signature** _____ **Date** _____

The retiree or beneficiary of a deceased retiree or member must complete this page.
Then take or mail both pages to your financial institution to verify your information.
Your financial institution must complete the second page and agree to the Master Agreement.

## RSA Direct Deposit Authorization

*This page to be completed by a representative of the financial institution.*

**Name** _____ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

**Financial Institution Information**

Depositor Account No _____ Bank Routing No _____

Financial Institution Name _____ Type of Account ☐ Checking ☐ Savings

Mailing Address _____
Street or P.O. Box City State ZIP Code

Name(s) of Person(s) on this Account _____

_____

_____

**Financial Institution Certification**

**MASTER AGREEMENT**

In accordance with the provisions of Section 3.6.4 of the 2012 National Automated Clearing House Association (NACHA) Operating Rules and Guidelines, both the Retirement Systems of Alabama (RSA), as the Originator, and the above named Financial Institution consider the following to be the Master Agreement, as defined by the NACHA Operating Rules and Guidelines, and agree that it is to be applicable to all payments sent by the RSA to the Financial Institution for the benefit of all benefit recipients having accounts with the Financial Institution.

In consideration of the RSA making benefit payments in accordance with this Direct Deposit Authorization without requiring proof that the retiree/beneficiary identified on this form is alive on the date on which such benefits are paid and are credited to his or her account, the Financial Institution agrees to repay and refund to the RSA, on demand, the full amount of any payments made to and received by the Financial Institution after the date of death of the benefit recipient, regardless of whether the account listed on this Direct Deposit Authorization contains sufficient funds for the refund. The Financial Institution further agrees to accept the certification of the RSA as to the date of death of such payee as sufficient evidence in accordance with Section 2.10 of the 2012 NACHA Operating Rules and Guidelines.

I, the undersigned, confirm that the identity of the above named retiree/beneficiary, account number, and type are true and accurate. As the representative of the above named Financial Institution, I certify that the Financial Institution agrees to receive and deposit the identified payments in accordance with the Master Agreement and pursuant to Section 3.6.4 of the 2012 NACHA Operating Rules and Guidelines, and that the Master Agreement is applicable to all payments sent by the RSA to the Financial Institution for the benefit of the retiree/beneficiary.

Representative Name_____

***Sign Here*** ➔ **Representative Signature** _____ **Date** _____
*Financial Institution*

Telephone Number _____

**Please return completed form to:**

The Retirement Systems of Alabama
P.O. Box 302150
Montgomery, AL 36130-2150
Fax: 334.517.7001

Properly completed Direct Deposit Authorization forms received by the RSA before the 13th of each month will be effective for the current month.

Mobile County Public School System
Division of Human Resources

# Resignation/ Notification of Intent to Leave System Employment

Form HR-610

| Employee Information | |
|---|---|
| Name of Employee | Employee Number |
| Which School or Work Site | Job Title |
| Current Mailing Address | |
| New or Forwarding Address, If Known | |
| Approximate First Date of Employment | Proposed Last Working Day |

**Type of Separation from the Mobile County School System**

***Check the appropriate type of separation:***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Retirement | | Resignation | | Health Reasons | | Other (Please Specify Below) |

**Reasons for Leaving**

***Check all the applicable reasons:***

| | | | | | |
|---|---|---|---|---|---|
| | Moving from the area | | Continue Education | | Dissatisfied [Specify reason(s) under Other] |
| | Family circumstances | | Hired elsewhere | | To seek higher salary and more benefits |
| | Illness in family | | Maternity/adoption | | |

Other (Please Specify)

**Insurance Continuation**

***Please check the appropriate box below:***

| | |
|---|---|
| | I do not want to have my insurance coverage continued. |
| | Please send me information explaining continuation of insurance coverage (COBRA) |

**Departing Checklist**

| ***Please check the box that most clearly represents your views.*** | Yes | No | Don't Know |
|---|---|---|---|
| 1. Did you meet with your supervisor to discuss leaving your employment? | | | |
| 2. Would you recommend this school system to another person seeking employment? | | | |
| 3. Do you believe that the Mobile County School System is a good place to work? | | | |
| 4. Would you return to work in this school system if you later had an opportunity? | | | |
| 5. Do you plan to work in another school system after you leave Mobile County School System? | | | |
| 6. Are you satisfied with the quality of your own work while employed in this school system? | | | |

7. What could Mobile County School System have done better to have made your employment more enjoyable?

**System Rating**

***Please check the appropriate box below:***

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Rate from one to five your overall satisfaction or degree of satisfaction with your work experience in the system, with five being the highest. | | | | | |

| | | | | |
|---|---|---|---|---|
| Signature of Employee | Date | | | |
| Name of Supervisor (Please Print) | Position | | | |
| Signature of Supervisor | Date | | | |
| Signature of HR Representative | | Approved | | Not Approved |

Mobile County PUBLIC SCHOOLS

# SICK LEAVE BANK
# NOTICE OF PARTICIPATION OR RESIGNATION

**Name** _____ **School/Department** _____

**Employee Number** _____ **Social Security Number** _____

**Designated Agent** _____
(Family or friend to discuss and sign on your behalf, if needed)

## NOTICE OF PARTICIPATION OPTIONS

☐ I wish to be a member of the Mobile County Public School System Sick Leave Bank and hereby authorize that two (2) days from my personal sick leave account be placed on deposit in the SLB. I have received a copy of the GUIDELINES for the SLB and hereby agree to comply with these guidelines as printed.

☐ I wish to be a member of the Mobile County Public School System Sick Leave Bank, but do not have the requisite number of days on account at this time. I hereby authorize two (2) days to be deposited as I earn and accumulate them. I have received a copy of the GUIDELINES for the SLB and hereby agree to comply with these guidelines as printed.

☐ I do not wish to participate in the Sick Leave Bank.

## NOTICE OF RESIGNATION

☑ I hereby terminate my participation in the SICK LEAVE BANK of the Mobile County Public School System. I request that my days on deposit be returned to my personal sick leave account. I understand that resignation can only occur:

*Upon resignation from the school system Last Day:_____

*Upon retirement from the school system Last Day:_____

*After completion of the regular school year

*During the first three weeks of the school year

By this resignation, I understand that I am no longer a member of the Sick Leave Bank and forfeit all benefits and privileges of the Sick Leave Bank.

_____ _____
Signature Date

**----------PLEASE RETURN via FAX, EMAIL or MAIL TO:----------**
Fax: (251) 221-6237 • MCPSS - Human Resources, Employee Relations, P. O. Box 180069, Mobile, AL 36618