APPLICATION TO JOIN SICK LEAVE BANK

ESCAMBIA COUNTY BOARD OF EDUCATION

1. Print Name:_____ School/Department:_____

2. Position:_____ Contract Days:_____

3. Please check only one of the following:

   - ❑ I wish to join the Escambia County Sick Leave Bank and by my signature hereon I authorize five days to be taken from my personal account and deposited into the Bank.

   - ❑ As a new employee without the minimum number of days required to join the Sick Leave Bank, I hereby request that the prerequisite number of sick leave days be transferred to the Sick Leave Bank enabling me to join.

   - ❑ I do not wish to join the Sick Leave Bank.

Employee's Signature:_____ Date:_____

Effective Date: July 1, 2002

By signature above I authorize the transfer of the days designated and agree to abide by the Sick Leave Bank Guidelines.

APPLICATION FOR LOAN FROM SICK LEAVE BANK

TO BE COMPLETED BY THE BORROWING EMPLOYEE

1. Print Name:_____

2. Social Security No:_____

3. School/Department:_____

4. Position:_____ Contract Days:_____

5. Number of days requested from the Bank:_____

6. Days to be used beginning on the following date:_____

7. Do you owe the Sick Leave Bank any days?_____

8. Is this a request for extended sick leave from the Sick Leave Bank?_____

   If so, how many additional days are requested?_____

9. Your Signature:_____ Date:_____

Application is made in compliance and shall be consistent with the Agreement between _____ _____ and the appropriate Sick Leave Bank Guidelines. By signature above, the applicant certifies that he or she is familiar with terms of the Agreement and the provisions of the Guidelines.

TO BE COMPLETED BY THE SICK LEAVE BANK CHAIRPERSON

10. Days awarded by this request:_____

11. Signature of Sick Leave Bank Chairperson:_____

12. Date:_____

PHYSICIAN CERTIFICATION OF CATASTROPHIC ILLNESS OR INJURY

Escambia County Board of Education

Name of Patient:_____

Social Security No:_____

School/Department:_____

I hereby certify that the above listed individual is a patient of mine and is suffering an illness or injury which will cause the patient to be absent from work for an extended period of time which is estimated by me to be at least one of the following:

- ❑ One Week
- ❑ Two Weeks
- ❑ Three Weeks
- ❑ One Month
- ❑ Permanently
- ❑ Indefinitely
- ❑ Other_____

PHYSICIAN'S STATEMENT (Print Clearly):_____

_____

_____

_____

_____

Signature of Physician:_____Date:_____

Print Physician's Name:_____

Physician's Address:_____

_____

Please return this form to the chairperson of the Sick Leave Bank.

NOTICE OF RESIGNATION FROM THE SICK LEAVE BANK

(Please Print)

Employee's Name:_____

Social Security No:_____

School:_____Position:_____

I hereby terminate my participation in the Escambia County Sick Leave Bank and request that days on deposit in the Sick Leave Bank be returned to my personal sick leave account, effective July 1 of this year.

_____ _____

SIGNATURE **DATE**

PHYSICIAN CERTIFICATION OF ILLNESS OR INJURY

Escambia County Board of Education

Name of Patient:_____

Social Security No:_____

School/Department:_____

I hereby certify that the above listed individual is a patient of mine and is suffering an illness or injury which will cause the patient to be absent from work:

FROM:_____ TO:_____

PERMANENTLY:_____
(Effective Date)

PHYSICIAN'S STATEMENT (Print Clearly):_____

_____

_____

_____

_____

Signature of Physician:_____Date:_____

Print Physician's Name:_____

Physician's Address:_____

_____

REQUEST FOR CATASTROPHIC LEAVE

Employee's Name:_____

Social Security No:_____

School:_____Position:_____Contract Days:_____

Dear Sick Leave Bank Committee:

I am requesting catastrophic leave for the following reason_____

_____

_____

_____

_____

I understand that the number of days available for my use will depend on the number of days donated by members of the sick leave bank.

_____ _____

SIGNATURE **DATE**

***PLEASE ATTACH A COPY OF THE PHYSICIAN'S CERTIFICATION OF CATASTROPHIC ILLNESS FORM.**

CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

DONATING EMPLOYEE INFORMATION

1.	Employee Name:
2.	Social Security Number:
3.	Employee Address:
4.	Employee Telephone(s):
5.	Employer:

BENEFICIARY EMPLOYEE INFORMATION

6.	Receiving Employee Name:
7.	Social Security Number:
8.	Beneficiary's Employer:

DAYS TO BE DONATED TO BENEFICIARY (Not to exceed 30 days)

9.	Number of days to be donated:

CERTIFICATION OF DONATING EMPLOYEE

10. I certify that I hereby donate the above noted number of my sick leave days to the beneficiary employee listed above. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his or her use due to a catastrophic illness/injury as defined by Act 93-753. it is my understanding that my sick leave balance will be reduced by the specified number of days hereon and that the donated days will not be returned to me.

Donating Employee's Signature:_____Date:_____

Witness:_____Date:_____

CERTIFICATION OF DONATING EMPLOYER

11. I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorized Signature:_____Date:_____

Title:_____

RECEIPT OF BENEFICIARY EMPLOYER

12. The above noted number of sick leave days have been credited to the sick leave account of the beneficiary employee. (Please give a copy of this form to the beneficiary employee.)

Authorized Signature:_____Date:_____

Title:_____