Sick Leave Bank Request Form
(Please Print or Write Legibly)

Date _____ Length of Service _____

Name _____

Address _____

_____

School or Department _____

Physicians Name _____

Physicians Address _____

_____

Employee Signature _____

READ AND SIGN MEDICAL RELEASE FORM BELOW AND SEND REQUEST TO TERESA MILLER, AT THE DIRECTOR OF SCHOOLS OFFICE

Physician's Statement

As required by the Sick Leave Bank Policy adopted by the DeKalb County Board of Education, all requests to utilize days from the Bank shall be accompanied by a physician's statement verifying the cause of illness or injury and attesting to the individual's inability to perform assigned duties. Refusal to supply such a statement shall result in the request being denied.. This information is to be used for the purpose of evaluating and handling my request for additional sick time from the DCBE Sick Leave Bank and for no other purpose, now or in the future.

_____ _____

Signature Date

PLEASE SUBMIT ANY AND ALL DOCUMENTATION PERTAINING TO ILLNESS