ATKINSON COUNTY SCHOOL SYSTEM
98 ROBERTS AVENUE EAST
PEARSON, GEORGIA 31642
(912) 422-7373

SICK LEAVE BANK WITHDRAWAL REQUEST FORM

NAME:_____ SS#:_____
(Please Print)

LOCATION (SCHOOL DEPT.):_____

NUMBER OF DAYS REQUESTED:_____ REASON FOR REQUEST:_____

_____

_____

SIGNATURE: _____ DATE: _____

RELEASE MEDICAL INFORMATION STATEMENT

By signing this statement, I hereby authorize my medical records/information, as pertaining to this request, to be released to the Sick Leave Bank Committee for review.

SIGNATURE:_____ PRINTED NAME:_____

DATE:_____

FOR PAYROLL USE ONLY

NUMBER DAYS USED:_____ LAST DAY WORKED: _____

NUMBER OF LEAVE DAYS AVAILABLE:_____

COMMENTS:_____

SIGNED:_____ DATE:_____

SICK LEAVE BANK TRUSTEE BOARD USE ONLY

DATE RECEIVED:_____
NUMBER DAYS REQUESTED:_____ NUMBER OF DAYS GRANTED: _____
HOW LONG HAS APPLICANT BEEN ILL/INJURED?_____WK/COMP?_____
LAST DAY WORKED:_____HAS CURRENT SICK LEAVE EXPIRED?_____ WHEN?_____
BOARD CHAIRPERSON SIGNATURE:_____DATE:_____

PLEASE ATTACH PHYSICIANS STATEMENT

Atkinson County School System

Physician's Form for Verifying Qualifying Illness or Disability of Employee

Name: Last First Middle	Department: (Attached Duties and Responsibilities) Supervisor Signature: _____ Date:
Social Security Number:	Employee's Job Title or Class Title:
Address:	Work Site:
City, State, Zip Code:	Work Telephone Number:

PHYSICIAN'S REPORT OF QUALIFYING ILLNESS

Physician's Name:	Date Disability Begins:	Estimated Date Disability Ends:
Group Name: Phone Number: Street Address: City, State, Zip Code:	[ ] I have read the attached list of duties and responsibilities. [ ] I certify that the above named employee is under my care and will be unable to perform normal duties during this period. Adjustments in these dates may be necessary at a later date. _____ Physician's Signature (No Stamp) _____ Date	