



**SICK LEAVE BANK REQUEST FORM**  
**HARALSON COUNTY SCHOOL SYSTEM**

Employee Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Date of Hire \_\_\_\_\_ Employee Number \_\_\_\_\_

Current Position \_\_\_\_\_ Current Location \_\_\_\_\_

Medical Documentation: Must be attached to request for consideration by the Sick Leave Committee.

Number of Days Requested: \_\_\_\_\_

Reason for Request:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I attest that all the information provided in making this request is accurate and that this request is made as a result of all other forms of sick leave/disability compensation having been exhausted.*

Employee Signature \_\_\_\_\_

\*\*\*\*\*

For Official Use Only:

Date Request Received: \_\_\_\_\_

Date of Sick Leave Bank Meeting: \_\_\_\_\_

Decision of Sick Leave Bank Committee: \_\_\_\_\_ Granted \_\_\_\_\_ Denied

If applicable, reason for denial:

\_\_\_\_\_  
\_\_\_\_\_

Director of Personnel \_\_\_\_\_

Signature

