



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:
