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