



LEON COUNTY SCHOOL BOARD
SICK LEAVE BANK
BENEFITS APPLICATION

Sick Leave Bank Policy requires this application be submitted within thirty (30) days of the date the applicant reaches leave without pay. One (1) physician's statement is required to accompany this application.

Applicant: \_\_\_\_\_ Work Location: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS#: \_\_\_\_\_

Date Submitted: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_

Are you eligible for any other type of benefits (Workers Compensation, lost wages from auto accident, disability)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name of company providing benefits: \_\_\_\_\_

I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim to the administrator of the Sick Leave Bank, Leon County School Board. (A copy of this authorization shall be as valid as the original). I also certify the information I have provided on this form is true, accurate and complete.

\_\_\_\_\_  
Applicant's Signature Date

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For Leave Accounting Use Only:

Application received on: \_\_\_\_\_ Member of the Sick Leave Bank: Yes \_\_\_\_\_ No \_\_\_\_\_

All leave expired on: \_\_\_\_\_ Five continuous days of unpaid leave ended on: \_\_\_\_\_

Application Approved: \_\_\_\_\_ Application Denied: \_\_\_\_\_

Credit up to \_\_\_\_\_ days from the Sick Leave Bank

Effective Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_ Hourly Rate of Pay: \_\_\_\_\_ Bargaining Unit: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_