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 Time & Attendance 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: _____