APPLICATION FOR SICK LEAVE BANK
HOUSTON COUNTY SCHOOL SYSTEM

EMPLOYEE NAME:____

SOCIAL SECURITY NUMBER:______________________________________

DATE OF EMPLOYMENT:____

POSITION:____

LOCATION:____

I HAVE READ AND UNDERSTAND THE POLICY GOVERNING THE SICK LEAVE BANK AND AGREE TO ABIDE BY ITS PROVISIONS. I FURTHER UNDERSTAND THAT THE BOARD OF EDUCATION, OVERVIEW COMMITTEE, AND PHYSICIANS INVOLVED IN THE APPROVAL OR DENIAL OF BENEFITS SHALL BE HELD HARMLESS BY MEMBERS OF THE SICK LEAVE BANK.

SIGNATURE:___________________________ DATE:________________

SUBMIT THIS APPLICATION TO CATHY SOLOMON IN THE BUSINESS OFFICE-8004. A COPY WILL BE RETURNED TO YOU. IF YOU HAVE ANY QUESTIONS CONCERNING THE APPLICATION OR SICK LEAVE BANK PROCESS, PLEASE CALL CATHY AT 988-6189 ext. 10253.

To safeguard your membership status, make sure you retain your approved copy of this enrollment form.

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BUSINESS OFFICE:

HCSS EXPERIENCE:____________

ACCUMULATED EARNED LEAVE:____________

ENROLLMENT APPROVED:____

EFFECTIVE DATE OF MEMBERSHIP:________________________________

HCBO-0003
REV. 08/30/2001

SICK LEAVE BANK WITHDRAWAL APPLICATION
(Please type or print clearly)

DATE OF REQUEST:______________________________

NAME:____ SS#:______________________________________

LOCATION:______________________________________ POSITION:_________________________________

DATE OF LAST DAY WORKED:_____________________ # DAYS REQUESTED:______________________

IS THIS YOUR FIRST REQUEST FOR THIS DISABILITY? ☐ YES ☐ NO
IF NO, HOW MANY DAYS WERE PREVIOUSLY APPROVED?_________

HAVE YOU BEEN GRANTED BANK DAYS FOR ANY PRIOR DISABILITY PERIODS? ☐ YES ☐ NO
IF YES, GIVE THE DATE(S) OF GRANT(S):_______________________________________

REASON FOR THIS REQUEST: (PHYSICIAN'S STATEMENT MUST BE ATTACHED)

____

____

PHYSICIAN'S NAME:_____________________________________ PHONE #:_________________________

YOUR MAILING ADDRESS:____

CITY/STATE/ZIP CODE:____

YOUR PHONE #:_________________________________

I HAVE READ THE POLICY GOVERNING THE OPERATION OF THE HOUSTON COUNTY SCHOOL SYSTEM SICK LEAVE BANK AND UNDERSTAND THAT THE DECISION OF THE COMMITTEE IS FINAL. I ALSO UNDERSTAND THAT, IF APPROVED, THIS GRANT IS FOR THE SPECIFIED NUMBER OF DAYS ONLY AND THAT ADDITIONAL APPLICATIONS MUST BE FILED WITH THE COMMITTEE IF ADDITIONAL BANK DAYS ARE NEEDED.

MEMBER'S SIGNATURE:____ DATE:______________________

RETURN THIS FORM TO CATHY SOLOMON IN THE BUSINESS OFFICE-8004. IF YOU HAVE ANY QUESTIONS, CALL CATHY AT 988-6189 ext. 10253.

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OFFICE USE ONLY

DATE REQUEST RECEIVED:________________________ PHYSICIAN'S STATEMENT: ☐ YES ☐ NO

DATE MEMBERSHIP BEGAN:_______________________ ORIG. HIRE DATE:________________________

MEMBER'S AVAILABLE LEAVE TERMINATES:___________________________________

COMMITTEE MEETING DATE:_____________________ REQUEST APPROVED:_____________________

DAYS GRANTED:______ TO BEGIN ON ____________________ AND END ON ______________________

IF DENIED, REASON:____

COMMITTEE'S SIGNATURE:______________________________________ DATE:______________________

HCBO-0002
REV. 08/30/2001