Gloucester City School District

**Request to Utilize Sick Leave Bank Days**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of time employed in district: \_\_\_\_\_\_\_\_\_\_\_\_\_ years \_\_\_\_\_\_\_\_\_\_\_\_\_ months

Current number of sick days remaining as of today’s date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sick Leave Bank days will not be granted until the employee has exhausted all accumulated sick leave days.**

**Circle One**: **I have / will have** used all of my available sick leave days for this school year.

**Circle One: I have / have not** previously used the Sick Leave Bank this school year.

Number of days I am requesting from the Sick Leave Bank: \_\_\_\_\_\_\_\_\_\_

Sick Leave Bank Days should begin: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

 *Month Day Year*

The above requested days are needed for the reason of injury, surgery, or critical illness of self as described below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A doctor’s statement on the physician’s letterhead, with the physician’s stamp/seal must be received with this application. It should state: The applicant’s name, the medical reason for request, and the estimated length of absence/return to work. Additional documentation may be required.**

**Submission of the form constitutes a waiver for the committee to review medical documents.**

**By signing this application, I agree that the decision by the Review Committee shall be final and binding and that no legal action will be taken against the Gloucester City Board of Education, GCEA, or Review Committee members, if the request is denied.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS FORM MUST BE COMPLETED IN FULL TO BE CONSIDERED.**

**INCOMPLETE INFORMATION WILL RESULT IN A DELAY IN CONSIDERATION.**

**Forms should be submitted to one of the following committee members:**

**Barb Sacchetti (GHS) LeAnn Deveraux (GMS) Gemma Shultes (CSS).**

# Sick Bank Use Request

Date Form is Being Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Number of Days Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Absence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



*For Committee Use Only:*

[] Request Approved [] Request Denied [] Request Approved

with Revisions





 **GCEA Committee Members** **GCBOE Committee Members**



Signature Date Signature Date



Signature Date Signature Date



Signature Date Signature Date