BOAZ CITY SCHOOLS

REQUEST AND AUTHORIZATION FOR SICK LEAVE BANK PARTICIPATION BY FULL-TIME, CERTIFIED AND SUPPORT PERSONNEL

_____

EMPLOYEE'S NAME (Please Print)

_____

SCHOOL

_____

SOCIAL SECURITY NUMBER

CHECK THE APPROPRIATE BOX:

☐ I wish to be a member of the Boaz City Schools Sick Leave Bank. I agree to follow all rules and regulations of the Sick Leave Bank.

I understand that I am responsible for the repayment of all borrowed days from the Sick Leave Bank and that in the case of my death, my estate will be responsible for repayment of any days I owe the Bank.

I authorize that five (5) days from my personal sick leave account be placed on deposit in the Sick Leave Bank. I further authorize a release of a record of the number of sick leave days accumulated in my account to the SLB Committee as needed.

☐ I am aware of the Sick Leave Bank opportunity and choose not to participate at this time.

_____ _____

Signature of Employee *Date*