

**SICK LEAVE BANK APPLICATION FORM
BUILDING ADMINISTRATOR AND NON- REPRESENTED EMPLOYEES**

Name _____ Employee ID: _____

Address _____ Phone: _____

Work Site _____ Position Title: _____

Emergency Contact Name/Phone: _____

Attending Health Care Provider Name/Facility: _____

I am requesting _____ days of sick leave bank (Not to be less than 6 days or more than 20 days)

Answer the following :

	<u>Yes</u>	<u>No</u>
1. I have been employed by the District for the last 12 months	%	%
2. I anticipate exhausting all applicable paid leave balances	%	%
3. Myself or an immediate family member has an extended/recurring illness/injury and is under a physician's care	%	%
4. My illness/injury is work related	%	%
5. I will not receive disability benefits while covered by sick leave bank hours	%	%
6. Relationship of family member (if applicable) _____		

I certify that the above information is _____