

SICK LEAVE BANK REQUEST

INSTRUCTIONS: ATTACH THE AUTHORIZED PHYSICIAN'S STATEMENT SIGNED BY THE PHYSICIAN AND FORWARD TO THE PERSONNEL COORDINATOR, WORCESTER COUNTY BOARD OF EDUCATION, 6270 WORCESTER HIGHWAY, NEWARK, MD 21841

(Prepare in duplicate.)

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME TELEPHONE \_\_\_\_\_

\_\_\_\_\_ SCHOOL TELEPHONE \_\_\_\_\_

SCHOOL \_\_\_\_\_

DATE SICK LEAVE EXPIRED \_\_\_\_\_ NUMBER OF DAYS REQUESTED FROM BANK \_\_\_\_\_

SIGNATURE OF MEMBER \_\_\_\_\_

COMMENTS:

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SICK LEAVE BANK COMMITTEE

REQUEST APPROVED \_\_\_\_ YES \_\_\_\_ NO

\_\_\_\_\_

Chairman

DATE \_\_\_\_\_

NUMBER OF DAYS APPROVED \_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_

COMMENTS:

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PAYROLL USE ONLY

DAYS GRANTED \_\_\_\_\_

DAYS USED \_\_\_\_\_

Approved \_\_\_\_\_

Appeal Process \_\_\_\_\_