



# Clarke County Board of Education Application for Participation in the Sick Leave Bank

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**School or Work Site**

I have read and understand the rules and guidelines set forth in the Sick Leave Bank.

\_\_\_\_\_ I wish to become a member of the Sick Leave Bank and hereby authorize that five (5) days from my personal sick leave account be placed on deposit with the Sick Leave Bank.

\_\_\_\_\_ I do not wish to participate in the Sick Leave Bank.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



# Clarke County Board of Education Notice of Resignation from the Sick Leave Bank

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**School or Work Site**

I hereby terminate my participation in the school system Sick Leave Bank and request that days I have on deposit be returned to my personal sick leave account.

NOTE:

One (1) copy of this form must be sent to the Payroll Department at the Central Office.

One (1) copy should be retained by the employee.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



# Clarke County Board of Education Catastrophic Sick Leave Approval Form

## Section I: Employee Information

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**School or Work Site**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

*An employee must be a member of the Clarke County School System Sick Leave Bank and receive approval from the Board prior to participating in catastrophic sick leave.*

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## Section II: Attending Physician's Statement

*A statement from the attending physician attesting to the need for the employee requesting catastrophic leave to be placed on extended leave.*

Name and Phone Number of Physician: \_\_\_\_\_  
\_\_\_\_\_

Physician's Statement: (may be attached or written) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Based on my professional opinion, I estimate that the person whose name is shown in Section I above will need to be away from his/her employment for \_\_\_\_\_ days.

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

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## Section III: Board Action

Approved by Board:      Yes \_\_\_\_\_      No \_\_\_\_\_      Date \_\_\_\_\_



# Clarke County Board of Education Catastrophic Sick Leave Transfer Authorization Form

## Section I: Donating Employee Information

Employee Name: \_\_\_\_\_

Employer: \_\_\_\_\_

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## Section II: Beneficiary Employee Information

Employee Name: \_\_\_\_\_

Employer: \_\_\_\_\_

*The beneficiary and donating employee must be a member of the Clarke County School System Sick Leave Bank or a member of the Sick Leave Bank in the public school system where he/she is employed.*

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## Section III: Number of Days Donated

I certify that I hereby donate \_\_\_\_\_ days of my regular state sick leave days to the beneficiary employee whose name is listed above in Section II. My employer has my permission to transfer the indicated number of sick leave days to the employee of the beneficiary for his/her use due to catastrophic illness/injury as defined by Alabama Legislative Act 93-753. I understand that my accumulated sick leave balance will be reduced by the specified number of days I have authorized to be transferred and that such days will not be returned to me.

\_\_\_\_\_  
**Donating Employee's Signature**

\_\_\_\_\_  
**Date**

*No more than 30 days may be donated by any one employee.*

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## Section IV: School System Authorization

I hereby certify that the donating employee is employed by the \_\_\_\_\_ Board of Education and has an accumulated balance of sick leave days equal to or greater than the number of days authorized for transfer. I further certify that the provisions of the Sick Leave Bank have been followed in authorization of this transfer of sick leave days.

\_\_\_\_\_  
**Personnel Office**

\_\_\_\_\_  
**Date**