

APPENDIX D-2

AATA SICK LEAVE BANK REQUEST FORM

Date _____

SECTION A – TO BE COMPLETED BY THE EMPLOYEE

Name: _____ Employee Number: _____

School to which assigned: _____ Position: _____

Home Address: _____

Telephone: Home/Cell _____ Work _____

Home email: _____

Accumulated to date:	Treasurer's Office Only
Sick Leave days:	
Personal days:	

- Number of days requested: _____
- Date to start usage: _____
- Date to return to work: _____

Describe the nature of your illness:

Physician's Name: _____

Address: _____

Phone Number: _____

Employee Signature _____

RETURN THIS FORM TO THE OFFICE OF THE AACS SUPERINTENDENT
Submission of this form does not indicate automatic approval

APPENDIX D-3

AATA SICK LEAVE BANK COMMITTEE FORM

SECTION B – TO BE COMPLETED BY THE SICK LEAVE BANK COMMITTEE

Employee's Name _____

Date Request Received _____

Physician's Statement attached

_____ YES

_____ NO

Member's Accumulated Leave (personal and sick) Ends/Ended

First Day of Work Missed for This Illness

_____ Request Granted

_____ Number of Days Granted From the Sick Leave Bank

_____ Request Denied

Signature or AATA Sick Leave Bank Committee Member

APPENDIX D-4

**AATA PHYSICIAN'S FORM FOR VERIFYING ILLNESS
TO THE SICK LEAVE BANK COMMITTEE**

Name: _____ Employee Number: _____

School to which assigned: _____ Position: _____

Home Address: _____

Telephone: Home/Cell: _____ Work: _____

Home email: _____

Physicians report of illness:

_____ Illness/Leave begins

_____ Estimated Date Illness/Leave Ends

Physician's Name: _____

Address: _____

Phone Number: _____

I certify that the employee named above is under my care and will be unable to perform normal duties during this period. Adjustments in these dates may be necessary at a later date.

Physician's Signature (no stamp) and Date

**RETURN THIS FORM WITH THE SICK LEAVE BANK REQUEST FORM TO THE
OFFICE OF THE AACS SUPERINTENDENT**