APPENDIX G-2
AACSE SICK LEAVE BANK REQUEST FORM

Date _____

SECTION A – TO BE COMPLETED BY THE EMPLOYEE

Name:_____ Employee Number:_____

Building assignment:_____ Position:_____

Home Address:_____

Telephone: Home/Cell_____ Work_____

Home email:_____

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

- Number of hours 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 G-3

AACSE 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 Hours Granted From the Sick Leave Bank

_____ Request Denied

_____

Signature or AACSE Sick Leave Bank Committee Member

APPENDIX G-4
AACSE PHYSICIAN'S FORM FOR VERIFYING ILLNESS TO THE SICK LEAVE BANK COMMITTEE

Name:_____ Employee Number:_____

Building assignment: _____ 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