REQUEST FOR SICK LEAVE DONATION PLAN BENEFITS

(Mail to Sick Leave Bank, P. O. Box 1724, Cumberland, MD 21502)

_____ _____

Name (Please Print) Date of Application

_____ _____

Social Security No. School or Work Location

☐ACEA ☐APSASAC

Employee Classification

_____ _____

Date Absence Began Date Absence Expected to End

Number of Days Requested_____

Reason for Request_____

_____

_____

Other pertinent information attached:

- ☐Physician's Statement
- ☐Family Information
- ☐Income Concern
- ☐Other

_____

Signature

This form must be accompanied by a physician's statement, which includes history of illness, date the illness began, a diagnosis and prognosis along with any other related information. In submitting this form, I grant permission for the SLB Committee to contact this physician should additional information be needed and to view any other relative information from my payroll and personnel records, such as my past history of leave usage. All information provided will be kept confidential.

Date of Hire_____ Years of Employment: Full Time _____

Leave Carried Into Current Year_____ Part Time_____

Current Amount of Unused Sick Leave_____ As of _____

Please complete all information above this line.

SLB Committee DISPOSITION

Approved: No. of Days_____ Denied_____

_____ _____

Committee Chairperson Committee Member

_____ _____

Committee Member Committee Member

_____ _____

Date Approved Committee Member