8.6F— SICK LEAVE BANK ENROLLMENT FORM

SICK LEAVE BANK ENROLLMENT FORM

Name: _____
First MI Last Suffix

Location: _____ **Position:** _____

Employee ID _____or last four digits of SSN _____

ENROLLMENT

In accordance with Policy 8.6, I request to be a participant in the Sick Leave Bank. I understand that an eligible employee may enroll by donating a minimum of one (1) sick leave day, but not more than three (3) sick leave days of his or her accumulated leave to the bank.

I desire to donate_____day(s) to the Sick Leave Bank. Each day donated is deducted from my accumulated sick leave.

_____ _____
Signature Date

DECLINATION

My signature below indicates that I have been given the opportunity to participate in the Sick Leave Bank; however at this time I do not wish to enroll.

_____ _____
Signature Date

Please, submit this form to the Payroll & Benefits Department.