Request for Sick Leave Bank Program Withdrawal

Office for Human Resources and Educator Quality
7227 Land O' Lakes Boulevard, Land O' Lakes, Florida 34638

Please type or print clearly.
To be completed by employee.

Today's Date _____

Employee's Name: _____ _____
LAST FIRST MIDDLE EMPLOYEE ID# ***or*** LAST 4 DIGITS of SSN

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone # (____) _____ **Cell Phone #** (____) _____ **Email** _____

Work Location: _____ **Job Title:** _____ ◯ **Inst.** ◯ **Noninst.** ◯ **Admin.**

Five (5) criteria for eligibility:

1. Must be a participating member.
2. Must have exhausted all of your personal Sick Leave.
3. Must have been absent with *or* without pay for at least ten (10) consecutive or ten (10) non-consecutive days within a ninety (90) day period that are related to the same illness or injury.
4. Must submit a signed ***Certification of Health Care Provider*** *(MIS Form #307 – Physician's Statement)* verifying incapacitating illness or injury.
5. Must have submitted a ***Request for Leave*** *(MIS Form #101)* designating the days requested as Health Leave.

Please check the following basic eligibility criteria:

YES	NO	
◯	◯	**1.** I am a participating member who has contributed to the Sick Leave Bank.
◯	◯	**2.** I have exhausted all my personal Sick Leave days.
◯	◯	**3.** I have been absent at least ten (10) consecutive or ten (10) non-consecutive days within a ninety (90) day period relating to the same illness or injury.
◯	◯	**4.** I have attached to this application a signed ***Certification of Health Care Provider*** *(MIS Form #307 – Physician's Statement)* verifying my incapacitating illness or injury.
◯	◯	**5.** I have submitted a ***Request for Leave*** *(MIS Form #101)* designating the days requested as Health Leave.

NOTE: Additional information may be required or requested in order for the Committee to make an informed decision to grant withdrawal of days.

In addition to the statement provided by my personal physician, I also agree, if requested to do so, to submit to an examination by a physician(s) of the Sick Leave Bank Committee's choice.

_____	_____	_____
Anticipated dates of absence	Employee signature or authorized signature if employee is unable to sign	Date