

SICK LEAVE BANK AUTHORIZATION FOR PARTICIPATION FORM

TROY CITY BOARD OF EDUCATION

Troy, Alabama

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This form is to be completed by any full-time employee wishing to join the Sick Leave Bank or by any participating Sick Leave Bank member wishing to terminate his/her participation in the program. Forms should be returned to the payroll department at the Central Office.

(PLEASE PRINT)

Employee's Name: _____ SS Number: ____/____/____
School/Work Site: _____ Position: _____

Check One: ☐ 9 month contract ☐ 10 month contract
 ☐ 11 month contract ☐ 12 month contract

PLEASE CHECK THE ONE BOX BELOW WHICH APPLIES:

- ☐ I wish to be a member of the Troy City Schools Sick Leave Bank and hereby authorize that three (3) days from my personal sick leave account be placed on deposit in the Sick Leave Bank. This entitles me to full rights of participation in the Sick Leave Bank program.
- ☐ I wish to TERMINATE my participation in the Troy City Schools Sick Leave Bank and I hereby request that the days I have on deposit there be returned to my personal account. I understand that any outstanding debt owed to the Sick Leave Bank will be deducted from my personal account of sick leave days, or from my salary, in accordance with SLB guidelines.