FILE: 5:12

AUTHORIZATION FOR SICK LEAVE BANK PARTICIPATION BY FULL-TIME, CERTIFIED-CLASSIFIED PERSONNEL

SYLACAUGA CITY SCHOOLS

PLEASE PRINT

EMPLOYEE'S NAME _____ SOCIAL SECURITY NUMBER _____

SCHOOL OR CENTER _____

_____ I wish to be a member of the Sylacauga City School System Sick Leave Bank and hereby authorize that two (2) days from my personal sick leave account be placed on deposit in the Sick Leave Bank.

_____ I wish to be a member of the Sylacauga City School System Sick Leave Bank, but do not have two (2) days in my account at this time. I hereby authorize the next two (2) earned days of sick leave for my account to be placed on deposit in the Sick Leave Bank.

_____ I do not wish to participate in the Sick Leave Bank.

DESIGNATED AGENT _____

SIGNATURE OF EMPLOYEE _____ DATE _____