# District 25 Sick Leave Bank
# Application for Sick Days

Employee Name ______________________________ Date ____________________

Work Location _______________________________ Employee Group: (please check one below)

- ☐ SASP
- ☐ TCARN
- ☐ Admin
- ☐ Food Services
- ☐ Other ________________

I am applying for available sick leave bank days due to: ____________ my own illness

____________ illness of immediate family member

If you checked the illness of immediate family member, please identify the employee's relationship to the family member:

- ☐ Spouse
- ☐ Parent-in-law
- ☐ Child
- ☐ Son-in-law
- ☐ Parent
- ☐ Daughter-in-law
- ☐ Other dependent living in your home – Please explain below:

__________________________________________________

Please list your anticipated date of return to work per your (family member's) doctor: ____________

***YOU MUST ATTACH A DOCTOR'S CERTIFICATE OF CONTINUING ILLNESS, INCLDING THE DATE THAT THE EMPLOYEE IS ANTICIPATED TO RETURN TO WORK.***

______________________________________ ____________________
Employee's Signature Date

**RETURN COMPLETED APPLICATION TO THE BENEFITS MANAGER**

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**DO NOT WRITE IN THIS SPACE BELOW – OFFICE USE ONLY**

Date when this employee has used all available compensation days: ________________________

Number of available Sick Leave Bank Days to eligible member if the Sick Leave Bank Committee approves this application: ________________

Approval Date: ____________

Declined Date: ____________

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