

MADISON COUNTY SCHOOLS

Authorization for Sick Leave Bank Participation

NAME: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

SCHOOL/WORK SITE: _____

POSITION: _____

I wish to become a member of the Sick Leave Bank and hereby authorize that five (5) days from my personal sick leave account be placed in the Bank.

I wish to become a member of the Sick Leave Bank, but do not have the five (5) days in my account to become a member. I hereby authorize the next five days earned to be placed in the Bank.

SIGNATURE

DATE

(Send completed form to Payroll Department)