REQUEST FOR SICK LEAVE DONATION PLAN BENEFITS

Name (Please Print) _____ Date of Application _____

School _____

Date Absence Began _____ Date Absence Expected to End _____

Amount of Days Requested _____

Reason for request _____

_____

_____

Other pertinent information (family information, income concerns, etc.)

_____

_____

_____

Signature _____

This form must be accompanied by a physician's statement that includes history of illness, date the illness began, a diagnosis and prognosis along with any other related information. In submitting this form, I grant permission for the SLDP Committee to contact this physician should additional information be needed.

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To Be Completed By the Personnel Office

Date of Hire _____ Years of Employment: Full Time _____

Leave Carried Into Current Year _____ Part Time _____

Current Amount of Unused Sick Leave _____ As of _____