

BTEAA & BTEA Members Initial Sick Bank Leave (SBL) Application

Please complete the information below to apply for initial use of the sick leave bank. The information provided must be as accurate as possible to ensure your application will be processed in a timely manner. Return the completed application to the Sick Bank Leave Officer, as designated by the BTEA. SBL applications will be reviewed by a three-member approval committee, appointed by the association, on a monthly basis. Information provided on this application will be shared with members of the Sick Leave Bank Committee and staff members of BTSD Human Resource Services, solely for the purposes of sick bank administration. After the application is reviewed and processing is finalized, applicants will be issued a letter informing them of their approval status. Please refer to the Sick Leave Policy 334 for all additional SBL policies and procedures.

Name: _____

Section A:

School/ Assignment:: _____

Home Address: _____

Phone Number _____

Section B- Membership: Please check the appropriate response

I am a:

_____ **BTEA or Administrator Sick Bank Member, first year of service within the district**

Applying for 20 Sick Leave Bank days available after 20 days of absence for the same illness/disability

_____ **BTEA or Administrator Sick Bank Member, second year of service within the district**

Applying for 25 days available from the bank after the first 25 days of absence for the same illness/disability during that year

_____ **BTEA or Administrator Sick Bank Member with three or more years of service within the district**

Applying for 30 days from the bank available after the first 30 days of absence for the same illness/disability during that year

Section C- Details of Sick Leave:

1. Total accumulated, non-donated, sick days to date: _____
2. Expected/Actual First day of absence for this medical condition _____
3. Expected/Actual Last day of absence for this medical condition _____
4. Number of your own sick days used for this medical condition to date _____

Section D Physicians Form: Complete the attached physician's form. The form must be completed and submitted along with application. SBL applications submitted without the completed physician's form will not be considered.

I hereby certify the above information to be true and correct. I am attaching the Sick Leave Bank Physician's Statement to verify this information. I understand and agree that the decision to award days from the Sick Leave Bank is at the sole discretion of the Sick Leave Bank Committee.

NAME _____ **DATE** _____

Section E: FOR COMMITTEE USE ONLY

Approved: _____ Yes _____ No; if denied, attach statement of reason(s)

Number of SB Days: _____

Beginning Date: _____ **Ending Date:** _____

SLB Chairperson BTEA:

Name: _____

Signature: _____

Date: _____

SLB Chairperson Admin:

Name: _____

Signature: _____

Date: _____