



ALABASTER CITY BOARD OF EDUCATION

SICK LEAVE BANK MEMBERSHIP APPLICATION/ CANCELLATION OF MEMBERSHIP

Print Name: _____

School/Site: _____

Please check only one of the following:

_____ I wish to join the ACS Sick Leave Bank and by my signature hereon I authorize two (2) days to be taken from my sick leave account and deposited into the Sick Leave Bank.

_____ As a new employee of ACS, without the minimum number of days required to join the Sick Leave Bank, I hereby request that the prerequisite number of sick leave days to be transferred to the Sick Leave Bank enabling me to join.

_____ I wish to join the ACS Sick Leave Bank, but do not have the minimum two days prerequisite; therefore, I authorize the transfer of two future sick leave day earnings to be deposited into the bank.

_____ I do not wish to join the Sick Leave Bank.

Employee's Signature

Date

By signing the above, I authorize the transfer of days designated and agree to abide by the Sick Leave Bank guidelines.

CANCELLATION OF MEMBERSHIP

_____ I wish to cancel my membership in the Sick Leave Bank. I request that my two (2) days be returned to my individual sick leave account.

Employee's Signature

Date