



CAROLINE COUNTY APPLICATION FOR USE OF SICK LEAVE BANK

I hereby request leave from the Caroline County Sick Leave Bank. I certify that I am a current member of the Caroline County Sick Leave Bank and that I have reviewed all requirements for this program.

Name: _____ Work Phone: _____
Department: _____ Home Phone: _____

Reason for Request: _____

Date incapacity will/did begin: _____
Date all leave will terminate: _____
Expected time needed to withdraw from the Sick Leave Bank: _____
Have you previously used the Sick Leave Bank? Yes _____ No _____
If yes, what was the date(s) and reason(s) of prior use? _____

I agree to provide Caroline County Administration the attached Physician's Statement and authorize a medical review to establish eligibility.

Employee Signature: _____
Date: _____
Dept. Director Signature: _____
Date: _____

For Office Use Only

Present Leave Balances:
Annual Leave: _____ Sick Leave: _____
Comp Time: _____
Recommendation: Yes _____ No _____ for: _____ hours of sick leave
Comments: _____
Signature for Approval: _____