

CONFIDENTIAL HCEA Sick Leave Bank Request

Harford County Education Association (HCEA)
c/o Harford County Public Schools
102 S. Hickory Avenue ♦ Bel Air, MD 21014
Telephone 410-588-5225 www.hcps.org

INSTRUCTIONS: To determine your eligibility to use HCEA's Sick Leave Bank, please complete the following:

1. Complete the form below by providing all requested information.
2. Download the Sick Leave Bank Physician's statement (2 pages) and scan/email completed copies to HCPS.
Attention: Brittany Brooks, email: Brittany.Brooks@hcps.org

Please provide all information. Incomplete forms will not be processed.

Check one (✓): Mr. Mrs. Ms. Dr. Employee ID Number _____

Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Non-Work Email _____

School/Department _____ School Phone _____

Position _____ Hire Date _____ (MM/DD/YY)

Reason for this sick leave bank request _____

Have you received treatment for any condition or illness in the past 90 days?

No Yes If yes, explain. _____

Type of Grant Request: Initial Request Extension Request

Was this illness/injury work related?

No Yes If yes, indicate date and status of application _____

Number of days or hours requested from the bank _____ (30-day maximum)

Specific dates of days required _____

**Dates must fall within what your treating physician indicates. You are responsible for knowing when your regular sick and personal days have been exhausted. HCPS will verify your available leave data and confirm on page 2 of the SLB application.*

If any portion of my application is falsified, it may result in disqualification for Sick Leave Bank grants and/or disciplinary action by my employer. By submitting this form, I certify that I have reviewed and that I am in compliance with all policies and procedures for Sick Leave Bank, including disclosure of any secondary employment. I hereby authorize the Harford County Board of Education to release information from my personnel file regarding my medical history, doctor's records and/or letters, and use of sick leave to the HCEA Sick Leave Bank Approval Committee, consent to the foregoing agreement and agrees to be bound by the terms and conditions of the Sick Leave Bank.

Name and ID of Applicant

Date (MM/DD/YY)

FOR INTERNAL OFFICE VERIFICATION

Verified Available Accrued Leave Dates: _____

Has applicant received previous SLB grants? Yes No If yes, how many? _____ Dates _____

Number of days of lifetime sick leave bank usage at time of application _____ (190-day lifetime maximum)

Requested SLB Grant Dates: _____ (marked below)

Month _____ 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Month _____ 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Note: All SLB grants become effective the first unpaid duty day following five (5) consecutive days of absence and the exhaustion of all available leave. Please indicate if this provision is waived for Cesarean birth. YES

FOR SICK LEAVE BANK COMMITTEE USE ONLY

Final Committee Vote: # _____ Affirmative # _____ Negative

SLB Committee Approval? Yes No Conditional

SLB Requested: # of days approved: _____ Dates Approved: _____

Comments/Notes _____

Meeting Facilitator Signature _____

Date: _____ / _____ / _____