Print

Volunteer State Community College
Sick Leave Bank Enrollment Application

( ) Faculty Sick Leave Bank ( ) Non-Faculty Sick Leave Bank

Employee Name: _____ V Number: _____

Social Security No.: _____

Department: _____ Position: _____

By my signature below, and upon acceptance of my membership by the Trustees, I acknowledge the following:

A. I am aware of the provisions of the Sick Leave Bank and do hereby relieve Volunteer State Community College from any liability as a result of actions by the Trustees.

B. I am aware of the initial assessment of fifteen (15) hours from my accumulated sick leave balance.

C. I understand this donation and subsequent assessments are final and may not be returned unless the bank is dissolved.

D. If it is necessary for the Trustees to assess additional days, I as a member may refuse; however, my membership in the Sick Leave Bank will be terminated.

E. I understand this authorization will remain in effect for this and subsequent years unless I cancel in writing.

_____ _____

Employee Signature Date

***For Office Use Only:* (record all data in hours)**

_____ Membership accepted _____ Membership denied*

Employee Sick Leave Bank Hours: _____

Date Certified: _____

*Reason for denial: _____

_____ _____

Approved by Chair of Sick Leave Bank Committee Date

Rev. 9/28/12