



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)

<input type="checkbox"/> Membership accepted	<input type="checkbox"/> Membership denied*
Employee Sick Leave Bank Hours: _____	
Date Certified: _____	
*Reason for denial: _____	

Approved by Chair of Sick Leave Bank Committee	Date