

Jacksonville City Schools
Sick Leave Bank Authorization for Participation

Name: _____ SSN: _____

School: _____

_____ I wish to be a member of the Jacksonville City Schools Sick Leave Bank and hereby authorize that five (5) days from my personal sick leave account be placed on deposit in the Sick Leave Bank.

_____ I wish to be a member of the Jacksonville City Schools Sick Leave Bank, but do not have five (5) days in my account at this time. I hereby authorize the next five (5) days earned for my account to be placed on deposit in the Sick Leave Bank.

_____ I do not wish to participate in the Sick Leave Bank.

Signature of Employee

Date