HARRISBURG SCHOOL DISTRICT
Application for Sick Bank Days
(Withdrawal Request)

To Be Completed by the Employee

Employee Name _____

Date in which all available sick leave is exhausted _____

Date of Request _____
(Must be no later than 5 working days following sick leave expiration)

Number of Days Requested _____

Reason for Request _____

_____

_____

_____

I have read and understand the Sick Leave Bank Policy.
By signing this request, I acknowledge and accept all provisions of the Harrisburg School District's Sick Bank Policy.

_____ _____
Employee Signature ***Date***

To Be Completed by the Employee's Physician- May be replaced with FMLA Physician's Certification, if applicable.

Physician's Name _____

☐ All information is provided with attached FMLA Physician's Certification.

-OR-

Health condition of the employee that requires an absence from work _____

_____

_____

Expected duration _____

_____ _____
Physician's Signature ***Date***

(FOR OFFICE USE ONLY)
REQUEST APPROVED: ☐ YES *# of Days Awarded*: _____ ☐ NO *Reason*: _____

DECISION DATE: _____
DATE EMPLOYEE NOTIFIED: _____ HR VALIDATION _____

Revised: 07-16-18