Print Form

STAFFORD COUNTY PUBLIC SCHOOLS
SICK LEAVE BANK MEMBERSHIP APPLICATION
VRS Plan 1 and Plan 2 and contracted Part-time Employees

Print Name: _____ _____ _____
Last First MI

☐ **I Do** ☐ **I Do Not Wish to Join the Sick Leave Bank**

I have read, understand, and accept the terms stated in the policy and regulations on the Sick Leave Bank. (See Policy 4710 and 4710-R.) I satisfy eligibility requirements for membership and wish to enroll in the Sick Leave Bank as of this date.

I understand that I must be an enrolled member of the sick leave bank for six (6) months before becoming eligible to receive benefits. Upon acceptance into the Sick Leave Bank, I authorize the donation of one sick leave day to the Bank. **A donated sick day to the Bank will not be returned to the donor under any circumstances.**

Signature: _____ **Date:** _____

Employee ID or SS Number: _____

Work Site Location: _____

Position: _____

☐ **Full-Time OR** ☐ **Part-Time**

Contract Beginning Date: _____

RETURN TO THE PAYROLL OFFICE

Revised 7/2015