

City of Winchester • Application for Sick Leave Bank Membership

Please type or print:

Name: _____
Last First M.I. Social Security Number

Department: _____

I hereby request to participate in the City of Winchester Sick Leave Bank and authorize the contribution of two times my monthly sick leave accrual rate to the bank. I understand that, each fiscal year hereafter, I may be required to contribute one times my monthly sick leave accrual rate to continue my participation. Additional contributions may be required if the bank balance falls below 240 hours.

I understand that sick leave contributions to the bank will not be returned if I cancel participation in the bank, terminate service with the City or the Sick Leave Bank policy is terminated.

I have read the Sick Leave Bank charter and understand the benefits of membership.

Employee Signature: _____ Date _____

For Office Use Only

Approved: _____ Disapproved: _____

Comments: _____

City Manager Signature Date: _____

<u>Fiscal Year</u>	<u>Hours Contributed</u>	<u>Hours Used</u>	<u>Dates of Use</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

City of Winchester • Sick Leave Bank • Physician's Statement

I hereby authorize my physician to release the information requested on this form and to provide additional information upon request of my employer.

Signature: _____

Date: _____

Please print name: _____

_____-_____-_____
Social Security Number

Dear Physician:

The above named employee is requesting benefits under the provision of the City of Winchester Sick Leave Bank. This program is maintained and supported by the contributions of sick leave days by individual members with the purpose of assisting an employee who is incapacitated by any illness or injury.

Please describe the nature of the illness or injury that will prevent the employee from fulfilling his/her work responsibilities:

I hereby certify that the above named employee of the City of Winchester is totally unable to meet work responsibilities due to the conditions described above. The return to work date is projected to be

_____.

Physician's Signature

Please print the following:

Name of Physician: _____

Name of Office: _____

Address: _____

Phone: _____