STAFF PERSONAL LEAVE AND SICK LEAVE BANK

VOLUNTARY CONTRIBUTIONS TO THE SICK LEAVE BANK:

- Staff members with less than twenty (20) accumulated days of sick leave may voluntarily contribute a maximum of one (1) day of earned/accrued sick leave. Staff members who have accumulated twenty (20) days of sick leave may voluntarily contribute a maximum of five (5) days of earned/accrued sick leave to the sick leave bank annually or, staff members who have accumulated sixty (60) days of sick leave may voluntarily contribute a maximum of ten (10) days of earned/accrued sick leave to the sick leave bank annually. Such contribution must be from the current year's sick leave earned/accrued leave.
- Each staff member contributing leave to the sick-leave bank must acknowledge a voluntary release of leave.
- In case of contributions exceeding the value of the sick leave bank limit, each contribution will be accepted on a first-come, first-served basis by date of signature.

LIMITS OF THE SICK LEAVE BANK:

- The maximum value of banked sick leave will be equal to the base salary of a teacher with a B.S. degree and no experience divided by $50.00/day. (26,540.00/50.00=530 days)
- No employee shall be entitled to receive banked sick leave by reason of contribution or employment.
- Additional leave will not be earned/accrued during the use of banked sick
- leave.
- Each approved applicant is limited to the one-time use of no more than one hundred (100) consecutive days of available sick leave from the sick leave bank in any school year.

ELEGIBILITY (for use of sick leave bank): The approved applicant shall:

- Only employees who have donated days will be eligible to request use of days from the bank.
- Be a full-time employee.
- Have a non-work related, seriously incapacitating, and extended illness or injury.
- Have exhausted all earned/accrued leave of any nature or kind.
- Be presently on unpaid leave status with the District.
- Not be eligible for disability benefits, including but not limited to Social Security, provided at District expense.
- Be one whose return to duty is projected to occur within a period no longer than six (6) months.
-

DETERMINING ELIGIBILTY:

- The Superintendent shall receive the applications and shall screen for and determine eligibility.

SICK LEAVE BANK DONATION FORM

Please read carefully the information below, sign, and submit to the Superintendent of Schools. Keep a copy for your records.

Employee name _____ Date_____

I desire to make a donation of sick leave and verify the following:

1. **I currently have accrued sick leave.**
2. **I understand that I may donate no more than one (1) day of sick leave in any contract year, with twenty (20) or less accrued sick leave, five (5) days of sick leave in any contract year, with twenty (20) or more accrued sick leave, or I may donate no more than ten (10) days of leave in any contract year with sixty (60) days or more accrued sick leave.**
3. **I understand that once my donated leave becomes part of the sick-leave bank it will not be returned to me.**
4. **I understand that days of leave, not my actual wage/salary, will be donated.**
5. **Information relative to this donation will remain confidential.**
6. **I make this donation voluntarily.**
7. **I currently have accrued _____sick leave days.**
8. **Number of days to be donated. _____**

_____ _____

Employee's Signature **Date**

_____ _____

Superintendent's Signature **Date**

☐ **Approved** ☐ **Disapproved** **Number of verified sick leave days_____**

SICK-LEAVE BANK REQUEST

Please read carefully the requirements for participation in the sick-leave bank listed below, sign, and submit to the Superintendent of Schools. A copy of this form will be returned to you.

Employee name _____ Date_____

I request to participate in the sick-leave bank and verify the following:

1. **I have depleted my accrued sick and personal and/or vacation leave as a result of serious illness or injury.**

2. **I understand that *serious illness or injury* is defined as "non-work-related illness or injury that is anticipated to last for a continuous period of time of four (4) or more weeks as verified by my licensed health care practitioner. (Childbirth is not considered a serious illness.)**

3. **I understand that any donated leave not utilized will be returned to the sick leave bank.**

4. **I understand that I am not eligible for this program once I qualify for disability coverage provided at District expense.**

5. **I give my permission, if necessary, for the Superintendent to verify or request additional information and/or documentation from the office of my attending licensed health care practitioner.**

6. **Based on my latest medical prognosis, I anticipate I will need _____ days.**

_____ _____
Employee's Signature **Date**

_____ _____
Superintendent's Signature **Date**

☐ **Approved** ☐ **Disapproved**

SICK LEAVE BANK
BOARD OF EDUCATION QUESTIONNAIRE

In order to help the Sick Leave Bank Committee to better understand your sick leave history, please briefly describe below the reasons for your previous absences. Include any long-term illnesses, which may indicate valid reasons for using your sick days.

Employee Name _____

Number of Years in the District_____

Reasons for absences _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Your cooperation is appreciated. The above information will assist the Board of Education in making an informed decision and will be kept confidential.

VERIFICATION OF SERIOUS ILLNESS OR INJURY

In order for an employee, _____ to use the sick-leave

Name

bank, Burlington School District RE-6J requires written verification by a licensed health care practitioner of serious illness or injury requiring an employee to be unable to work.

1. **Nature of serious illness or injury:**

   _____
   _____

   _____
   _____

   _____
   _____

   _____
   _____

2. **Beginning date of serious illness or injury** _____
   _____

3. **Expected date employee may return to work**_____
   _____

_____ _____
___

Signature of Licensed Health Care Practitioner **Date**

_____ _____

Typed or Printed Name **Telephone Number**

Federal Tax ID # of health care provider_____

This form is to be completed by the licensed health care practitioner and returned to the Superintendent's Office with the application of request to participate in the sick-leave bank.