SUFFOLK PUBLIC SCHOOLS
SICK LEAVE BANK
MEMBERSHIP ELECTION
ONE (1) DAY CONTRIBUTION REQUIRED

NAME: _____

EMPLOYEE ID NUMBER: _____

POSITION: _____

SCHOOL/LOCATION: _____

_____ **YES, I wish to become of member of the Suffolk Public Schools Sick Leave Bank. I authorize the contribution of one (1) day of my accumulated sick leave to the bank. I have reviewed and understand the policy of the Sick Leave Bank.**

_____ **NO, I do not wish to become a member of the Suffolk Public Schools Sick Leave Bank.**

_____ _____

SIGNATURE **DATE**

NOTE: THIS FORM MUST BE RETURNED TO THE FINANCE DEPARTMENT NO LATER THAN OCTOBER 15TH.