

REQUEST FOR REIMBURSEMENT OF EXCESS SICK LEAVE

Application must be submitted no later than April 15th.

NAME: _____ DATE: _____

By making application for reimbursement of excess sick leave, by signature below, I am agreeing to the following conditions:

- I must continue to carry a sick leave balance that is at least equal to the limits established under Family and Medical Leave in Policy GCBD-R1/GDBD-R1.
- This application is subject to fund availability and may be denied solely on that condition.
- I will forfeit all rights to reimbursed sick days. They will no longer be provided as an available balance or be able to be requested in the event of a health concern for myself or my family.
- Sick leave will be reimbursed at a rate of \$30 per day for up to 100 days per fiscal year provided funds are available.
- Once payment is made, the decision is irrevocable.
- This application cannot be used in the year of retirement to increase payment of accrued sick leave.
- The School Board or its employees shall not be held responsible for the decision of an employee to request reimbursement of excess sick leave.

I am an eligible employee and wish to make application for _____ days of excess sick leave.

EMPLOYEE SIGNATURE: _____

Submit This Form to the Business Office

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OFFICE USE ONLY:

The above individual has met the required guidelines _____ YES _____ NO

BUSINESS MANAGER RECOMMENDATION:

Request for _____ days were _____ Approved _____ Denied.

Reason for denial: _____

SUPERINTENDENT’S (DESIGNEE’S) SIGNATURE: _____

DATE: _____

cc: Employee
Personnel File
Business Manager