ECKCE CERTIFIED/LICENSED STAFF SICK LEAVE POOL APPLICATION

Name___________________________

Address____

Telephone _______________________________

Number of days requested ___________

1. Attached to this application is a statement from the attending physician verifying the serious illness of: (check one)
____ myself ____ my family member

2. I am aware of the rules for the use of the sick leave pool, and limits on the number of days which I may receive.

3. I realize that my request must be turned in by the last teacher work day of the contract year, and will not be considered after that date.

Teacher's signature___________________________

Signature for teacher__________________________
(if teacher is unable to sign)

Date ______________