Sick Leave Bank Enrollment

To Authorize Sick Leave Bank Participation

EMPLOYE INFORMATION	
Name:	
Department:	**Employee Number:**

I wish to enroll in the Madison County Sick Leave Bank and I hereby authorize Madison County to transfer 8 hours of my accrued Sick Leave to the Sick Leave Bank. I under-stand that the 8 hours is not revocable but will remain in the Bank for use by eligible recipients. Membership in the Sick Leave Bank affords me the opportunity to request leave time should I be faced with a catastrophic medical emergency. Membership also enables me to donate leave to the Bank and/or to a designated qualified recipient. I understand that I may withdraw my membership at any time. Should I withdraw my membership, I understand that I will not be able to renew my membership until the designated enrollment period.

Employee Signature: _____ Date: _____

TO BE COMPLETED BY HR	
Date Received:	**Date Posted:**