



# Sick Leave Bank Enrollment

To Authorize Sick Leave Bank Participation

## EMPLOYEE INFORMATION

**Name:**

**Department:**

**Employee Number:**

I would like 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 understand 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. 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:**