The following forms will be used by the College District for the sick leave bank:

Exhibit A: Sick Leave Bank Enrollment Form — 1 page

Exhibit B: Sick Leave Bank Application Form — 2 pages

Exhibit C: Request for Educational Leave — 1 page

Exhibit D: Community Service Leave (CSL) Request Form — 1 page

EXHIBIT A

SICK LEAVE BANK ENROLLMENT FORM

Name (Last, First, M): _____

SS# or Colleague ID #: _____

College Campus: _____

I understand that an eight-hour deduction will be made from my annual sick leave on September 1 of each year and contributed to the sick leave bank. In addition to the eight hours, I wish to contribute _____ sick leave hours (not to exceed 16 hours) on September 1 of each year. (Note: The maximum annual contribution is limited to 24 hours).

The deduction will continue annually until the employee directs otherwise in writing or unless policy changes. If an employee chooses to terminate his or her enrollment in and contribution to the sick leave bank, access to the bank by that employee will be limited to the number of hours contributed by the employee.

_____

Employee Signature Date

Failure to sign and date the form will void the transfer.

Return the **original** completed form to:

Human Resources Coordinator
Flores Building
Uvalde Campus

EXHIBIT B

SICK LEAVE BANK APPLICATION FORM

A qualifying illness or injury is a condition defined by the Family and Medical Leave Act's (FMLA) "Serious Health Condition" provision as outlined in the sick leave bank and FMLA policy. This sick leave bank is an option only after an employee exhausts all paid leave (sick, vacation, compensatory leave) available to the employee under the College District's policy.

Employee Name: _____

Colleague ID or SS#: _____

Campus Location: _____

Reason leave is requested: _____

_____

An ATTENDING PHYSICIAN'S STATEMENT is required for the employee. Attach any additional supplemental information to a separate page.

Amount of Leave Requested: _____

As an eligible College District employee, I am requesting _____ days to begin on _____ (date).

Sick Leave Bank Days: Upon exhaustion of all paid leave, an employee may request up to 90 days for the employee's personal illness or injury. Access to the sick leave bank is available only once during the employee's employment with the College District. Exclusion: Normal pregnancy without complications.

_____

Employee's Signature Date Supervisor's Signature Date

_____

President's Signature Date HR Coordinator's Signature Date

Human Resources Office Use Only

Date of benefit: _____ First day not present on the job: _____

Date paid leave ends: _____ Has current leave been input: _____Yes _____No

Does employee have disability insurance coverage? ___Yes ___No Type __STD __ LTD ___Both

Employee applied for disability insurance? _____Yes _____ No

Is the employee applying for/or on workers' compensation? ____Yes (Beginning on _____) ____No

Has the employee returned to work? _____Yes ____No Return to work date: _____

Comments: _____

_____ Approved Leave time is recommend for _____ days _____ hours, or until employee returns to work, whichever occurs first.

_____

President HR Coordinator Date

Sick Leave Bank Hours Input:_____ Input By: _____

EXHIBIT C

REQUEST FOR EDUCATIONAL LEAVE

Name of Employee: _____ Date: _____

Department/Title of Position: _____

Title of Course/Training: _____

Agency/Institution Providing the Course/Training: _____

Brief statement of the purpose of the course/training:

_____
_____
_____

Dates and times of the training: _____

Note: Upon approval, documentation must be provided to the immediate supervisor to demonstrate the registration for the course/training. Documentation must also be submitted to the immediate supervisor to show completion of the course/training and be recorded in the "PD Planner."

Approval date: _____

Supervisor signature/date: _____

Employee signature/date: _____

Reasons for denial:

_____
_____
_____

Date: _____

Supervisor signature/date: _____

Employee signature/date: _____

EXHIBIT D

COMMUNITY SERVICE LEAVE (CSL) REQUEST FORM

Name of Employee: _____

Department: _____

Date and Location of CSL: _____

Number of Hours Requested: _____

Description of CSL Activity:

_____
_____
_____
_____
_____
_____

I understand that the hours I use for CSL must be reported on my monthly absence report and that I cannot exceed 16 hours for the fiscal year.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____