

**KENTUCKY LEAGUE OF CITIES
SICK LEAVE BANK REGISTRATION FORM**

Name of Donor: _____

Department: _____

I hereby certify that this donation is given without expectation or promise for any purpose other than that stated in the Kentucky League of Cities Sick Leave Bank Policy. I also understand that I must make an initial donation of fifteen (15) hours of sick leave time to participate in the sick leave bank program and that I will be assessed 7.5 hours per year for the following three years to continue participation. In addition, I acknowledge that I will be assessed 7.5 hours every other year beginning on the fifth year of participation in the sick bank program. I may also be required to donate additional donations of sick leave time when the Sick Leave Bank falls below a certain monetary value, as determined by the executive management.

Signature of Donor

Date

This is to certify that the employee named above has a sufficient sick leave balance to donate the hours indicated in the Kentucky League of Cities Sick Leave Bank Policy.

Signature of Sick Leave Bank Administrator

Date

To be completed by donor's payroll officer

Donor's Sick Leave Balance: _____ - donation _____ = _____ sick leave balance

Copies to: Employee Personnel file
 Employee

Revised 12/06