

SICK BANK ENROLLMENT

I would like to join the sick bank. My information is as follows:

Name: _____

SS#: _____

Address: _____

Home Phone: _____

Position and/or School: _____

Date Employed: _____

I am authorizing Somerset County Public Schools to deposit three (3) of my sick leave days to the Sick bank as required for new membership.

Signature: _____ Date: _____