



**SICK LEAVE BANK ENROLLMENT FORM
ENROLLMENT FORM**

I, _____, hereby request that I be enrolled in the Accomack County Sick Leave Bank. I understand that enrollment is voluntary and that eight (8) hours of my current sick leave balance will be deducted upon enrollment. I also understand that additional assessments may be made to keep the sick leave bank at a total above 480 hours (60 days).

I understand that enrollment in the sick leave bank is limited to the first 30 calendar days of employment or during the month of May. Furthermore, I have reviewed the Sick Leave Bank Policy contained in the Accomack County Personnel Manual and I am aware that there are limitations regarding use of the sick leave bank.

(Signature)

(Date)