CATASTROPHIC LEAVE BANK

FAIRFIELD-SUISUN UNIFIED

WITHDRAWAL APPLICATION

TEACHERS ASSOCIATION

Name_____ **Date**_____

Address _____

Phone_____ **School/department**_____ **Position**

Number of days _____

Dates requested_____

Name of physician _____

Physician's phone number _____

Circumstances (provide pertinent details) _____

_____

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(ATTACH MEDICAL VERIFICATION)

I have used all of my available sick leave. I have read and understand all of the rules regarding the use and administration of Article 23.3 - Catastrophic Leave Bank.

I hereby certify that all statements made herein are true and correct to the best of my knowledge. I understand a false statement may result in my application to withdraw days from the Catastrophic Leave Bank will be disqualified.

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Signature of the employee or person designated by the employee