Teacher Unit SFT
Sick Leave Bank Membership Application

Name _____

Street Address _____

City, State, Zip _____

School _____

By signing this application to the Sick Leave Bank I am authorizing the SCSD/SFT Sick Leave Bank Committee to deduct two days of my accumulated leave for my first year of membership and one additional day each school year thereafter if deemed necessary by the Sick Bank Committee.

By signing this application I am agreeing that the decisions of the Sick Leave Bank Committee are final and not subject to the grievance procedures outlined in Article 4 of the SFT contract and I am waiving my right to any and all challenges, claims, and/or grievance against the district, the federation or the member of the Sick Leave Bank Committee presently or in the future that may arise from the administration of the

This must be received by November 17th either by having a Building Director bring it to the SFT Building Director Meeting on that date or emailing to Mike Silvestri at SFTPres@gmail.com

Your membership is appreciated!

Signature _____ Date _____