ATTACHMENT B

VACATION LEAVE BANK WITHDRAWAL REQUEST

TYPE OR PRINT:

1. **a.) Your Name (Last, First, Middle)** | **b.) Social Security Number** | **c.) Classification (Job Title)**

2. **Number of hours requested(not to exceed 480 hrs in a 12 month period) _____**

3.

DIAGNOSIS: _____ **DATE OF LAST EXAM:** _____

PROBABLE PERIOD OF INCAPACITATION: **FROM:** _____ **TO:** _____

I _____ **,** **a duly licensed physician/doctor**
(Typed or printed name of Physician/Doctor)

in the State of Alabama, certify that the above-named individual is under my care for the above medical reason(s) and due to this problem is unable to perform fully the duties of his/her regular position until the time noted.

_____ _____
Signature of Attending Physician/Doctor **Date**

4. **Hourly Income or Grade & Step**

$ _____

Accrued Leave Balance

Vacation	_____	**Hours**
Sick	_____	**Hours**
Comp Time	_____	**Hours**

5.

Supervisor's Name _____

Telephone #'s Home:_____ **Work:** _____ **Cell:** _____

Timekeeper's Name: _____ **Phone:** _____

I authorize the Vacation Leave Bank Committee to review my employment records for evidence of poor leave and attendance; use of vacation and/or sick leave reflecting a pattern of use contemporaneous with accrual; absence of a reserve of vacation and/or sick leave in relation to length of employment; poor job performance evaluations, record of disciplinary action that reflects negatively on reliability, trustworthiness, veracity, and job loyalty; and, absence of reasonable evidence to disprove indications of abuse of vacation and sick leaves.

_____ _____
DATE **EMPLOYEE SIGNATURE**
(If able to sign)
or
Supervisor or Timekeeper Signature