FONTANA UNIFIED SCHOOL DISTRICT
CERTIFICATED CATASTROPHIC LEAVE BANK WITHDRAWAL

PLEASE NOTE: SUBMIT ALL COPIES OF THIS FORM TO THE HUMAN RESOURCES OFFICE. DISTRIBUTION WILL BE MADE AFTER APPROVAL

____As a certificated unit member, I wish to withdraw _____ days from the Certificated Sick Leave Bank.

_____ _____ _____
Unit Member's Signature | Location | Date

_____ ***XXX-XX-*** _____
Employee's Name (Please Print) | Social Security Number

Please describe the details of the catastrophic illness or injury:

_____
_____
_____

____Statement from Doctor is attached to this form.

Committee Action:

_____ _____ _____ _____
Approved | Disapproved | Committee Chair | Date

_____ _____
Payroll Signature | Date

White - Payroll Yellow - Human Resources Pink - Employee Goldenrod - Association