



SICK POOL LEAVE AGREEMENT

Complete and submit this form to Human Resources Department.

Fax: 904.209.2414

Email: bccbenefits@sjcfl.us

I, _____, have read and understand the St. Johns County Sick Pool Leave policy (Administrative Code 408), and I hereby voluntarily contribute 40 hours of my accrued sick and/or vacation leave to the St. Johns County Sick Pool.

Please take _____ hours from my sick leave balance and/or _____ hours from my vacation leave balance for a total contribution of 40 hours to the Sick Pool Leave.

I understand that I will not be eligible to join the St. Johns County Sick Pool unless I have accrued a minimum of 80 hours of sick and/or vacation leave.

I understand that leave hours contributed to join or remain active in the St. Johns County Sick Pool are forever forfeited.

I understand that I may be required to donate additional hours to the St. Johns County Sick Pool on an annual basis to maintain membership.

Employee Signature

Date

Department name

Employee #

For Use by Human Resources Department Only

Current Sick Leave Balance: _____ Updated Sick Leave Balance: _____

Current Vacation Leave Balance: _____ Updated Vacation Leave Balance: _____

Date Sick Pool Processed: _____ HR Signature: _____