Teacher Sick Leave Bank Membership Application
SCSD/SFT

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.

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 outlines 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 Sick Leave Bank.

Withdrawal of member from the Sick Leave Bank must be in writing and received by the Sick Leave Bank Committee at the address of the offices of the **SFT, 740 Union Street, Schenectady, N.Y. 12305 no later than December 23, 2016.**

Your membership is appreciated!

Signature _____ Date _____