Application for Voluntary Withdrawal

Name: ______________________________

Social Security Number: ______________________________

Department: ______________________________

I, the undersigned employee/member, request that my membership in the

☐ Sick Leave Pool ☐ Compassionate Leave Pool

be terminated effective the first day of the month following receipt of this form by the Human Resources Department.

Members who withdraw from participation from either the Sick or Compassionate Leave Pool may not reapply for membership for a period of 12 months.

______________________________ ______________________________
Employee Signature Date

TO BE COMPLETED BY THE HUMAN RESOURCES DEPARTMENT

Employee deleted from the ☐ Sick/☐ Compassionate Leave Pool effective ______________