PRINT

RESET

MURRAY STATE UNIVERSITY
SICK LEAVE BANK DISCONTINUA TION FORM

Section I. Employee Information(Please Print)

Employee
Last Name _____ First _____ M.I. _____ M No. _____

Department _____ Position Title _____ Office Phone No. _____

Section II. Sick Leave Bank Discontinuation

I hereby request that my participation in the Murray State University Sick Leave Bank be discontinued effective immediately (the date of my signature). I understand that any donations previously contributed are irrevocable and that I am not eligible to withdraw days from the Sick Leave Bank unless I re-enroll during the next open enrollment period.

(1)_____ _____
Employee's Signature Date

(2)_____ _____
Human Resources Signature Date

Return to: **Human Resources**
404 Sparks Hall
Murray State University
Murray, KY 42071