EXTENDED SICK LEAVE APPLICATION

Name:_____ Social Security # ____/_____/_____

Address:_____ Phone: _____

_____

City State Zip Code

Estimated delivery date: (if maternity) _____

Location (school): _____ Position_____

If teacher, grade **and/or** subject: _____

Reason for leave: _____

_____

Last day you will work: _____

Last day covered by sick leave: _____

Effective date of extended sick leave: _____

(to be filled out by Central Office only)

Date you will return to work: _____

Balance of 90 days of extended leave: _____
(Contact Dena Louviere/ Ext. 4189 for this information)

Signature of employee: _____

Date requested: _____

Signature of Human Resource Director:_____

Date Reviewed:_____

Physician's statement must be attached

The Human Resources Office must be notified upon delivery

Note: Please obtain a Return To Work Release Form from the Human Resources Office before returning to your work place.