REQUEST FOR EXTENSION OF SICK LEAVE FORM

To be forwarded by the Employee to the Employee/Labor Relations Administrator.

A. NAME: _____ Date: _____

B. TITLE: _____ JOB GRADE: _____

C. DATE OF INITIAL EMPLOYMENT AT THE UNIVERSITY: _____

D. TOTAL NUMBER OF WORKING DAYS REQUESTED: _____

FROM: MONTH: _____ DAY: _____

TO: MONTH: _____ DAY: _____

E. WORKING DAYS OFF THE PAYROLL PRIOR TO REQUESTED LEAVE: _____

FROM: MONTH: _____ DAY: _____

TO: MONTH: _____ DAY: _____

Attach statement from physician indicating the nature of the illness and the expected date of return to work.

_____ _____

Employee's Signature Date

TO BE COMPLETED BY THE EMPLOYEE/LABOR RELATIONS ADMINISTRATOR

A. Date received : _____

B. Date of Decision : _____

C, Decision: _____ APPROVED _____ DISAPPROVED

_____

Employee/Labor Relations Administrator

_____

Date

cc: AFSCME Local 1776