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