APPENDIX B
REQUEST FOR EXTENSION OF SICK LEAVE FORM

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

A. NAME: _____ DATE: _____

B. E-MAIL: _____ PHONE #: _____

C. TITLE: _____ JOB GRADE: _____

D. DATE OF INITIAL EMPLOYMENT AT THE UNIVERSITY: _____

E. TOTAL NUMBER OF WORKING DAYS REQUESTED: _____

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 LABOR RELATIONS ADMINISTRATOR

A. Date Received:

B. Date of Decision:

C. Decision: _____ APPROVED _____ DISAPPROVED

_____

Labor Relations Administrator

_____

Date

cc: AFSCME Local 1776 President