

\*\* Only if required

## Certifed/Classified

## ABSENCE REQUEST

Date Submitted	School/Dept:					
Employee Name	yee Name(Please Print)					
Date of Absence						
	·	54-34-4-1-4-1-4-1-4-1-4-1-4-1-4-1-4-1-4-1				
FOR THE FOLL	OWING REASON:					
		(Certified)			(Classified)	
	Sick Leave		_ Full Day		Hours	
	am pm		_ Half Day			
	(Circle One)	al Illness				
	rersona	ai iiiiiess				
	Family Illness  Death in Family					
	Death in	ii raiiiiy			Relationship	
	D1	(Certified)	E. II D		(Classified)	
	Personal am pm		_ Full Day Half Day		Hours	
	(Circle One)		_ nan bay			
**	Vacation		_Days		Hours	0 (5)
*Anyone w	ishing to make use of va	cation must subn	nit a request to the	Superinte	ndent through their Supervis	or five (5) days in advance.
	Other - Jury Duty	y, Comp. Tim	ie, etc.			
					* Falsification of either	this statement or a physician's
					certificate shall be grounds	of for disciplinary action which may de dismissal.
					020 11	1 59039 25 7.00
					Sul	b Needed: Yes
	Employee	Cianatura			=	N -
Employee Signature						No
AS PRINCIPAL OR SUP	PERVISOR LHERERY VE	RIFY THE AROV	F ARSENCE TO RI	CORREC	FAND TRUE TO THE BEST (	DE MY KNOW! EDGE
	EKTIOOK, THEKEET TE	Au T THE ABOV	L'ABSENCE TO BI	CORREC	AND INCLIC THE BEST	A MI KNOWLEDGE.
Approved	d	Not Approve	d _	n .	. 1/0	
				Princ	cipal/Supervisor	Date
<b>T</b>		N A	,			
Approved		_Not Approve	a -	**Sı	uperintendent	Date