LEAVE DUE TO PERSONAL ILLNESS

Employee's Name _____ Building _____

Date(s) of illness or injury _____

Doctor's Certificate Attached: Yes _____ No _____
(Employees absent for three consecutive work days or more must attach a doctor's certificate.)

I hereby certify that the information provided above is correct.

_____ _____
Signature Date

_____ Approved

_____ Disapproved

_____
Administrator's Signature

Revised 9/17/18