Rochester City School District

EMPLOYEE REQUEST FOR HALF PAY SICK LEAVE

TO: Employee Benefits, Human Resources

Employee Name: ____________________________

Employee Address: ____________________________

Social Security Number or Employee ID: ____________________________

Date of Birth: ____________________________

Union: ____________________________

Work Location: ____________________________

Hire Date: ____________________________
(Minimum 1 Year of Continuous Service)

I hereby request an Extended Sick Leave at One-Half Pay for the following medical reason:

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I understand that under the provisions of my contract, I must first exhaust all of my illness allowance, personal business and vacation days before becoming eligible for Half Pay Sick Leave.

I also understand that this benefit can only be used once every twelve (12) months, no matter how short the duration of One-Half Pay is used.

I will provide a completed Attending Physician's Statement within seven days of exhausting all full pay accruals.

If approved, the Extended Sick Leave will be retroactive to the date of eligibility. Sick leave does not apply to off-duty days.

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Signature

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Date

Enclosure (Rev. 12/04)