

APPLICATION FOR ABSENCE FROM DUTY

Employee's Name _____

Date(s) of Absence _____

SICK LEAVE

Reason for Absence (check one) () Personal Illness

() Illness in Family (relationship) _____

() Funeral (relationship) _____

Nature of Illness _____

Name of Attending Physician _____

Name of Hospital _____

Name(s) of Physician Consulted _____

I hereby certify that I was physically incapable of performing my duties on the date(s)
Indicated above.

(Employee's signature)

PERSONAL LEAVE

Date _____

(Employee's signature)

PROFESSIONAL LEAVE

Date _____

(Employee's signature)

VACATION LEAVE

Date _____

(Employee's signature)

Approved _____ Disapproved _____

Date _____ Supervisor _____

Falsification of a statement is grounds for suspension or termination of employment
under sections 3319.141, 3319.081 & 3319.16 of the Ohio Revised Code.