

OLEAN CITY SCHOOL DISTRICT
410 West Sullivan Street
Olean, NY 14760

ABSENCE REQUEST FOR SUPPORT STAFF

Employee Name:

Leave is requested for the
following date(s):

Start Time

End Time

Total Hours

☐ VACATION (Section 4.1 - 12 Month Employees Only)

☐ SICK (Section 4.22)

☐ FAMILY SICK (Section 4.23 - please specify family member)

☐ PERSONAL (Section 4.21 - personal days are not permitted the day before or the day after a school recess, vacation or holiday without prior approval from the superintendent)

☐ BEREAVEMENT (Section 4.24 - please specify family member)

☐ OTHER (Section 4.27, 4.28 - ex: School Business, Association Time, Jury Duty -please give brief explanation below)

COMMENTS:

DATE:

EMPLOYEE SIGNATURE:

DATE:

PRINCIPAL/SUPERVISOR
APPROVAL:

DATE:

DIRECTOR OF HUMAN
RESOURCES APPROVAL:

DATE:

SUPERINTENDENT SIGNATURE:
(If Applicable)

☐ **APPROVAL**

☐ **DENIAL**

SUPERINTENDENT
COMMENTS:

☐ Personnel File
(if applicable)

☐ FMLA Notification provided to employee (if applicable)

FMLA Start Date: