

**UNION LOCAL SCHOOL DISTRICT  
APPLICATION FOR SICK LEAVE**

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Building: \_\_\_\_\_

Job Description: \_\_\_\_\_

The undersigned says that he/she is hereby making application for the use of sick leave as provided in the following Revised Code 3319.141 and that the use of such sick leave is justified for the following reasons:

I. Reason for use of leave:

- |  |   |
|--|---|
| A. <input type="checkbox"/> Personal Illness | D. <input type="checkbox"/> Exposure to Contagious Disease                |
| B. <input type="checkbox"/> Personal Injury  | E. <input type="checkbox"/> Illness, Injury or Death in immediate family  |
| C. <input type="checkbox"/> Personal Exam    | F. <input type="checkbox"/> Death Outside immediate family (one per year) |

II. Was medical attention required (If C is selected above check **Yes**)?

Yes  No

III. If yes, please indicate the name and address of the physician/dentist and the date consulted.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dates Consulted: \_\_\_\_\_

IV. If E is checked above, please give the name, address, and relationship of such members of your immediate family. If F is checked above, please give the name and address of the deceased.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

I hereby request \_\_\_\_\_ day(s) of sick leave (certificated & administrative employees only)

\_\_\_\_\_ hour(s) of sick leave (classified employees only-must be equivalent to 1/4, 1/2 or 1 day with a minimum of 1 hour)

beginning \_\_\_\_\_ AM/PM \_\_\_\_\_ and ending \_\_\_\_\_ AM/PM \_\_\_\_\_

\_\_\_\_\_ time \_\_\_\_\_ date \_\_\_\_\_ time \_\_\_\_\_ date

\_\_\_\_\_  
Signature of Employee

Falsification of this Statement is grounds for suspension or termination of employment under Section 3319.16 of the Ohio Revised Code.