JOAQUIN ISD

ABSENCE FROM DUTY REQUEST FORM

8/1/2022

USE THIS FORM ONLY WHEN ACCESS TO EMPLOYEE PORTAL IS NOT AVAILABLE

Employee _____ Campus/Department_____

Beginning Date_____ Ending Date_____ Total Days Absent_____

(All **DISCRETIONARY LEAVE** must be requested at least **TWO DAYS IN ADVANCE** and cannot be taken for more than **TWO CONSECUTIVE DAYS**)

LEAVE TYPE REQUESTED

Leave requests will be granted in accordance with board policy DEC and Employee Handbook. If order of leave taken is not specified it will be used in accordance with procedures in the Employee Handbook. (Check leave type and reason)

STATE PERSONAL (05)	LOCAL SICK (01) STATESICK (07)	OTHER
_____**Discretionary** (personal)	_____ **LOCAL SICK (01)** Earned 2 days/year beginning Oct., 2016 *(accumulates)* _____ **STATE SICK (07)** (accumulated prior to May, 1995)	____Staff Dev **(95)** _____School Business **(99)** Location_____ Date_____ Title _____ _____(include explanation)
_____**Nondiscretionary** (illness, emergency)	_____Illness of employee _____Illness of immediate family _____Family emergency _____Death of immediate family	_____Assault Leave _____Vacation **(90)** _____***Compensatory Time(80)*** *(must be used before leave)* _____Other_____(explain)

EXTENDED SICK LEAVE **Number of Days (max of 20):_____**

After all state and local leave has been exhausted, an employee who is unable to return to work for an extended period of time due to "personal illness or injury, including pregnancy-related illness or injury, or illness or injury of immediate family, shall be granted ***20 days of extended sick leave***. When such leave is granted, **the daily rate of pay for a certified substitute or one-half of the employee's daily rate of pay (whichever is less) shall be deducted** for each day of extended sick leave taken, whether or not a substitute is employed. Note this extended sick leave does not apply unless the employee is out for the same condition for an extended period of time.

PHYSICIAN'S STATEMENT REQUIRED—SEE NEXT SECTION BELOW

PHYSICIAN'S STATEMENT - An employee absent more than **five consecutive workdays** because of personal illness or illness of immediate family shall submit medical certification of the illness.

Date Illness Began: _____ Probable Duration of Illness: _____

Reason for Illness: _____ Date Employee May Return to Work: _____

Illness of: _____Family _____Employee (mark one)

I certify a necessary absence from duty for more than five consecutive days due to the above illness:

_____

Physicians Signature **Date**

Employee Signature	***Date***
Supervisor /Principal Signature	***Date***

SUBSTITITUTES

NAME	Circle Pay Code ND CD CR	DATE	UNITS WORKED
	ND CD CR		