

APPENDIX B

REQUEST FOR EXTENSION OF SICK LEAVE

To be completed by the employee and forwarded to the Chief Executive Officer (CEO) of the College.

NAME _____ DATE _____

TITLE _____ JOB GRADE _____

DATE OF INITIAL APPOINTMENT AT THE COLLEGE _____

TOTAL NUMBER OF WORKING DAYS REQUESTED _____

FROM: MONTH _____ DAY _____

TO: MONTH _____ DAY _____

WORKING DAYS OFF THE PAYROLL PRIOR TO REQUESTED LEAVE _____

FROM: MONTH _____ DAY _____

TO: MONTH _____ DAY _____

ATTACHMENT: Statement from a physician indicating the nature of the illness and anticipated date of return to full time duties.

EMPLOYEE SIGNATURE

DATE

To be completed by the CEO and returned to the Employee

DATE RECEIVED BY THE CEO _____

DATE OF DECISION BY THE CEO _____

DECISION BY THE CEO: APPROVED FOR _____ DAYS OF

EXTENDED SICK LEAVE

DISAPPROVED _____

SIGNATURE OF CEO

DATE

cc: Campus Union Official