DODDRIDGE COUNTY SCHOOLS

Claim for Personal Leave Pay

Name of Employee: _____ Position: _____

Address: _____

(St. or RFD) (City) (State) (Zip)

I hereby certify that I was absent from work on the dates and for the reasons listed below:

Date Reasons

(See reverse for definitions)

_____ 1. Personal Illness

_____ 2. Death in immediate family. Please circle member of family: Spouse. son, daughter, mother, father, or anyone living in that immediate household (5 consecutive calendar days allowed); brother, sister, father-in-law, mother-in-law, grandmother, grandfather, daughter-in-law, son-in-law, brother-in-law, sister-in-law, grandchildren, stepchildren, stepfather, and stepmother. (3 consecutive calendar days allowed.)

_____ 3. Personal Leave Without Cause (3 days) - Each person is allowed three (3) days personal leave without reason each year. These days shall not be taken consecutively without prior approval and shall not be used in connection with a concerted work stoppage or strike. EMPLOYEES ARE PERMITTED TO CARRY OVER TWO (2) DAYS OF THE THREE (3) ANNUALLY TO THE NEXT ENSUING YEAR. FIVE (5) DAYS WILL BE THE MAXIMUM ALLOWABLE NUMBER OF LEAVE WITHOUT CAUSE DAYS PERMITTED IN ANY SCHOOL YEAR. NO MORE THAN THREE (3) CONSECUTIVE DAYS MAY BE TAKEN IN ANY YEAR. CARRY OVER DAYS, IF UNUSED, WILL NOT ACCUMULATE.

I do solemnly swear that the information on this form is accurate, truthful and complete to the best of my knowledge.

_____ _____

Employee Signature Social Security Number

I agree with the above request - Yes___ No___ If no, state reason. _____

_____

Principal or Supervisor: _____

(Employee will not use this space)
Days allowed (this report) __

Daily Salary $_____

Total Payment (this report) _____
Budget Code _____
Note: All claims must be made at end of each school month for that month.

(Statement of Physician when required)
This is to certify that I treated _____
(Employee's Name)
and that incapacity was due to _____
(Name of Illness)

_____
(Physician's Signature)