Anderson
School District Five
Building Tomorrow Today

**WORKERS COMP
NO _____
YES _____

NOTIFICATION OF NEED FOR LEAVE OF ABSENCE

NAME_____ DATE _____

HOME ADDRESS _____

SCHOOL EMPLOYED _____

ASSIGNMENT _____ DATES OF EMPLOYMENT_____

I request a leave of absence to begin _____and end _____
(Date) (Date)

Reason for Request _____

Please attach a physician's statement indicating your need for a leave of absence.
Any employee absent due to personal illness or illness in the immediate family for five or more consecutive work days shall submit a physician's certification concerning the illness.

_____
Signature of Employee

LEAVE BEYOND 91 WORK DAYS

I understand that this leave, if granted, will be from School District Five and not from a specific position or school if beyond 91 work days.

_____
Signature of Employee

I am aware of the above request for leave of absence:

_____ _____
Signature of Principal or Immediate Supervisor Date

Additional Comments:

_____

_____

Extended leave (more than 91 work days) approved by the Board of Trustees on _____
Date