COMPENSATION AND BENEFITS LEAVES AND ABSENCES

DEC (EXHIBIT)

EXTENDED SICK LEAVE – EMPLOYEE MEDICAL REQUEST FORM (An acute injury or illness that poses an immediate risk to the employee's own personal health or immediate family)

Date:			
Request # for Academic Year			
Attach PfISD Extended Sick Leave Physician's V	erification	Form. Forward All Co	pies to the Leave Office.
CAMPUS/LOCATION		JOB TITLE	
NAME			
First	Middle		Last
ADDRESSStreet		State	Zip
Street	City	State	ΖΙΡ
E NUMBER #		PHONE:	
NUMBER OF DAYS REQUESTED FROM BANK		(3 days maximum, 1 day minir	num)
REQUEST IS FOR ABSENCES RELATING TO: Self Spouse Son/daughter Parent			
REASON FOR LEAVE REQUEST:			
VERIFICATION OF DATES OF ABSENCE(s) FOR V	WHICH LEA	VE IS REQUESTED:	
EMPLOYEE'S SIGNATURE:			Date:
EXTENDED SICK LEAVE OFFICIAL (OFFICE USE	E ONLY)		
Request Approved: Yes No Signatu	ıre:		Date:
			1 of 2

COMPENSATION AND BENEFITS LEAVES AND ABSENCES

DEC (EXHIBIT)

EXTENDED SICK LEAVE - PHYSICIAN VERIFICATION FORM

This form must be completed by the physician. Doctor's notes may accompany the form but will not be used for approval.

Request for Extended Sick Leave

Employee Information

NAME					
	First	Middle		Last	
ADDRESS					
	Street	City	State	Zip	
I authorize	the release of medical info	ormation to Pflugerville	ISD for consid	eration of requeste	d leave.
Employee S	Signature:				
Date:					
Medical dia	IPLETED BY PHYSICIAN agnosis of the condition(s)				
PHYSICIAN	S NAME (Please Print)				
PHYSICIAN	S SIGNATURE				
ADDRESS					
	Street	City	State	Zip	
Date					