ESST Request Form

Request Earned Safe & Sick Time for Payment

EMPLOYEE INFORMATION – complete all boxes

Employee Name Print Legal Name		**Position**	
Address		**BLDG / DEPT**	

REQUESTED DATE(S) AND HOUR(S) – complete all boxes

Date	Start Time	End Time	Hours Request	Reason for Request
TOTAL HOURS =				
RATE OF PAY				
TOTAL AMOUNT TO BE PAID =				

Select one:
- ☐ Athletic Worker
- ☐ Community Education
- ☐ Substitute Teacher
- ☐ Substitute Para

Budget Code(s):								**% Split:**
		E						
		E						

EMPLOYEE APPROVAL – sign form and submit to Supervisor; forms are due on a weekly basis.

I certify the request is an authorized and actual expense for ISD #885 – STMA Schools and meets School Board policies and guidelines.
By signing, I declare under the penalties of law that this amount, claim or demand is just and correct and that no part of it has been paid.

Employee Signature: _____ Date: _____

SUPERVISOR APPROVAL – review and sign form; submit to the District Office-Human Resources

By signing, I verify the accuracy and completeness of this claim to the best of my knowledge.

Supervisor Signature: _____ Date: _____

Skyward: Do not submit time off in Skyward. Human Resources will deduct requested ESST hours.

DISTRICT OFFICE ONLY

Human Resources - ☐ SmartFind ☐ True Time ☐ Sick Leave Deducted Sick Leave Code: _____ Entered By & Date: _____

Payroll - Pay Date: _____ Pay Code: _____ Entered By & Date: _____