OLEAN CITY SCHOOL DISTRICT
410 West Sullivan Street
Olean, NY 14760

UNPAID REQUEST FORM

EMPLOYEE NAME:

UNPAID LEAVE REQUEST DATE(S)/TIME:

START DATE: **END DATE:**

START TIME: **END TIME:**

Comments:

☐ MEDICAL (Please attach Doctor Script)

Comments:

☐ SERIOUS ILLNESS of Family Member
(please specify family member)

Comments:

☐ OTHER (please give brief explanation below)

DATE: EMPLOYEE SIGNATURE:

DATE: ASSISTANT SUPERINTENDENT:

DATE: SUPERINTENDENT: ☐ APPROVE ☐ DISAPPROVE

RETURN TO WORK DATE:

☐ Doctor Release Attached
(if applicable)