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

ABSENCE REQUEST FOR SUPPORT STAFF

Employee Name:

Leave is requested for the following date(s):

Start Time | End Time | Total Hours

☐ VACATION (Section 4.1 - 12 Month Employees Only)

☐ SICK (Section 4.22)

☐ FAMILY SICK (Section 4.23 - please specify family member)

☐ PERSONAL (Section 4.21 - personal days are not permitted the day before or the day after a school recess, vacation or holiday without prior approval from the superintendent)

☐ BEREAVEMENT (Section 4.24 - please specify family member)

☐ OTHER (Section 4.27, 4.28 - ex: School Business, Association Time, Jury Duty -please give brief explanation below)

COMMENTS:

DATE: EMPLOYEE SIGNATURE:

DATE: PRINCIPAL/SUPERVISOR APPROVAL:

DATE: ASSISTANT SUPERINTENDENT:

DATE: SUPERINTENDENT SIGNATURE: (If Applicable) ☐ **APPROVAL** ☐ **DENIAL**

SUPERINTENDENT COMMENTS: