LAKE ELSINORE UNIFIED SCHOOL DISTRICT

SUBSTITUTE EMPLOYEE SICK LEAVE FORM

Date:_____

PLEASE MARK THE APPROPRIATE CLASSIFICATION

☐ CLASSIFIED ☐ CERTIFICATED

Substitute Employee name: _____

Employee # _____

Job # _____ Name of Site Declined:_____

Date Declined: _____ Hours Declined: _____

Reason for Declining:_____

_____

Substitute Employee signature: _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

I certify that this request meets the requirement for use of sick leave as defined by AB 1522 effective July 2015.

PERSONNEL SUPPORT SERVICES OFFICE USE ONLY

CLASSIFIED STAFF:	APPROVED ☐	DENIED ☐
CERTIFICATED STAFF:	APPROVED ☐	DENIED ☐

Comment: _____