JOAQUIN ISD

ABSENCE FROM DUTY REQUEST FORM

9/20/2021

Employee ____ **Campus/Department**___________

Beginning Date_______________ **Ending Date**_________________ **Total Days Absent**____________

(All **DISCRETIONARY LEAVE** must be requested at least **TWO DAYS IN ADVANCE** and cannot be taken for more than **TWO CONSECUTIVE DAYS**)

LEAVE TYPE REQUESTED

Leave requests will be granted in accordance with board policy DEC and Employee Handbook. If order of leave taken is not specified it will be used in accordance with procedures in the Employee Handbook. (Check leave type and reason)

STATE PERSONAL (05)	LOCAL SICK (01) STATESICK (07)	OTHER
________**Discretionary** (personal)	________ **LOCAL SICK (01)** Earned 2 days/year beginning Oct., 2016 *(accumulates)* ________ **STATE SICK (07)** (accumulated prior to May, 1995)	____Staff Dev **(95)** _____School Business **(99)** Location___________ Date______________ Title _________________ _________________(include explanation)
________**Nondiscretionary** (illness, emergency)	______Illness of employee ______Illness of immediate family ______Family emergency ______Death of immediate family	______Assault Leave ______Vacation **(90)** ______***Compensatory Time(80)*** *(must be used before leave)* ______**REMOTE WORK (RM)**-***COVID19 only*** *(No **Leave used**)* ______Other__________________(explain)

COVID19-EXTENDED LOCAL LEAVE (21) for 2021-22---*10 day limit for Quarantine for Close Contact*
10 day limit for Employee Sick Positive Case

_________ #Days for ***Quarantine(Close Contact)*** or ______# Days ***Sick Leave Positive Case***

This leave is only used if the employee was not working from home(see REMOTE WORK above)

EXTENDED SICK LEAVE **Number of Days (max of 20):**______________

After all state and local leave has been exhausted, an employee who is unable to return to work for an extended period of time due to "personal illness or injury, including pregnancy-related illness or injury, or illness or injury of immediate family, shall be granted ***20 days of extended sick leave***. When such leave is granted, **the daily rate of pay for a certified substitute or one-half of the employee's daily rate of pay (whichever is less) shall be deducted** for each day of extended sick leave taken, whether or not a substitute is employed. Note this extended sick leave does not apply unless the employee is out for the same condition for an extended period of time.

PHYSICIAN'S STATEMENT REQUIRED—SEE NEXT SECTION BELOW

PHYSICIAN'S STATEMENT **-** An employee absent more than **five consecutive workdays** because of personal illness or illness of immediate family shall submit medical certification of the illness.

Date Illness Began: ___________________ **Probable Duration of Illness:** ___________________________

Reason for Illness: ___________________ **Date Employee May Return to Work:** _____________________

Illness of: _______**Family** _____**Employee** (mark one)

I certify a necessary absence from duty for more than five consecutive days due to the above illness:

____

Physicians Signature **Date**

Employee Signature	***Date***
Supervisor /Principal Signature	***Date***

SUBSTITITUTES

NAME	Circle Pay Code	DATE	UNITS WORKED
	ND CD CR		
	ND CD CR		