Paid Sick Leave Report Form

Name ______________________

Last 4 of SSN ______________________

Date/s Absent ______________________

Total # of Hours ______________________

Reason- Please check one below

______ Medical Care - Self
______ Medical Care - Family Member
______ Domestic Violence Issue
______ School related appointment
______ Public Health Closure

Additional Comments

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Employee Signature

____

Date: ______________________

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2/5/19 2/5/19