Paid Sick Leave Request Form

Name ____________________

Last 4 of SSN ____________________

Date/s Requested ____________________

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

____
____
____

Employee Signature

____

TeleSearch Manager Approval

____

Date of Approval: ____________________

2/5/19

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