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**Employee Verification for Authorized Use of Accrued Paid Sick Leave**

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| --- | --- | --- | --- |
| **Last Name**Click here to enter text. | **First Name** Click here to enter text. | **Title** Click here to enter text. | **Employee A Number**Click here to enter text. |

Per the college policy concerning use of paid sick leave for more than three (3) consecutive scheduled working days I am/or was required to work, I am providing verification that establishes or confirms my use of paid sick leave is/was for an authorized purpose.

I am providing the following documentation:
[ ]  Health care provider documentation (attached)
[ ]  A written statement indicating that the use of paid sick leave is/was necessary to take care of myself or a family
 member (attached)
[ ]  Domestic Violence/Sexual Assault/Stalking documentation attached (see the paid sick leave policy for the list of
 acceptable documentation)
[ ]  Child school/place of care of “Notice of Closure” (attached)
I attest that I used accrued paid sick leave for at least one of the authorized reasons on the following date(s):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Shift Type** | **Start Time** | **End Time** | **Total Hours Requested**  |
| Click here to enter a date. | Choose an item. |  Click here to enter text. Choose an item.  |  Click here to enter text. Choose an item.  | Click here to enter text. |
| Click here to enter a date. | Choose an item. | Click here to enter text. Choose an item.  | Click here to enter text.Choose an item. | Click here to enter text. |
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| Click here to enter a date. | Choose an item. | Click here to enter text.Choose an item. | Click here to enter text.Choose an item. | Click here to enter text. |

I understand that knowingly providing false information about the use of accrued paid sick leave could result in discipline, including dismissal.
**OR**[ ]  I do not have any of the requested documentation listed above and to provide it would be an
 unreasonable burden and/or expense.

Providing this is an unreasonable burden or expense for the following reason:

|  |
| --- |
| Click here to enter text. |

Click here to enter text.
Employee’s Signature Date

|  |
| --- |
| **To Be Completed by Employer** [ ]  Approved [ ]  Denied By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If denied, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |