

ORLAND UNIFIED SCHOOL DISTRICT
Orland, California 95963

NOTICE FOR TIME OFF WORK

To be submitted to the District Superintendent in duplicate for
action at least 2 days prior to time off as requested below.

Name: _____

Date: _____ School Site: _____

TIME OFF REQUEST

| Date(s) | Time | Reason | Reason Code |
|---------|--|--------|---|
| | <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day Times: | | A = Scheduled doctor appointment B = Bereavement Leave (Immediate Family - enter relationship) D = Family Illness E = School Business PN = Personal Necessity Leave (for specific purposes - off sick leave) N = No Tell Day (off sick leave) FH = Classified Floating Holiday J = Jury Duty V = Vacation X = Other (Explanation Required) |
| | <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day Times: | | |
| | <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day Times: | | |
| | <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day Times: | | |
| | <input type="checkbox"/> Full Day <input type="checkbox"/> Partial Day Times: | | |

Comments:

Please note: If employee is supervised by more than one person, signatures of all supervisors must be obtained prior to submission of request for time off to District Office.

| | | | | | |
|-----------------------------------|------|-------------------------|------|-------------------------|------|
| Signature of Principal/Supervisor | Date | Signature of Supervisor | Date | Signature of Supervisor | Date |
|-----------------------------------|------|-------------------------|------|-------------------------|------|

DISPOSITION:

APPROVED **DENIED**

FULL PAY DEDUCTION PARTIAL DEDUCTION (COST OF SUBSTITUTE) OFF SICK LEAVE

Comments:

Superintendent/Designee

Date