

Bethany School  
Application for **Sick** Leave

Name \_\_\_\_\_ Position \_\_\_\_\_

Number of sick days requested \_\_\_\_\_

Actual **day(s)** of absence(s): Please circle: M      T      W      Th      F

Actual **date(s)** of absence(s): \_\_\_\_\_

Please include actual hours of absence: From \_\_\_\_\_ to \_\_\_\_\_

Faculty school hours are:            Monday and Tuesday            7:45 a.m. to 4:00 p.m.  
   Wednesday, Thursday, & Friday            7:45 a.m. to 3:15 p.m.

Leave is assessed as follows:      Up to 2 hours - 1/4 day            2 hours to 4 hours -1/2 day  
   4 hours to 6 hours - 3/4 day            6 hours or more - 1 day

Is a substitute needed in your absence?      \_\_\_\_\_ Yes            \_\_\_\_\_ No

For partial days list all class times for which coverage is needed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The time indicated above is hereby requested due to the following circumstance:

\_\_\_\_\_ Personal Illness. Nature of illness \_\_\_\_\_

\_\_\_\_\_ Dr. Appt.

\_\_\_\_\_ Illness of family member (Spouse, Parent, Child). Nature of illness \_\_\_\_\_

\_\_\_\_\_ Personal Injury. Nature of injury \_\_\_\_\_

\_\_\_\_\_ Exposure to contagious disease which could be communicated to others: Explain:  
\_\_\_\_\_

\_\_\_\_\_ Death in immediate family (Spouse, Parent, Child, Sibling, Grandparent or Grandchild)  
Explain: \_\_\_\_\_

If a doctor, dentist or other professional was consulted, please indicate name and date: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Signature of Head of School

\_\_\_\_\_  
Date submitted

\_\_\_\_\_  
Date approved

Please return the completed form to David Gould. A copy will be returned to you after being processed.

\_\_\_\_\_ copied    \_\_\_\_\_ calendar    \_\_\_\_\_ computer            \_\_\_\_\_ substitute \_\_\_\_\_