



MEMORANDUM

**DAY-TO-DAY ABSENCE EXCEEDS BEYOND THREE (3) MONTHS
OR FOR CONSECUTIVE 100-DAY GRANT REQUEST**

Employee Name: _____

Social Security Number: _____

Classified Employee Certificated Employee Calendar _____ FTE:

Payroll: _____ Location: _____

Number of Days Absent for _____ Fiscal Year as of _____ : _____
Date Days

Last Day Worked: _____

Physician's Statement(s) on File? Yes No (Attach Copies)

Number of Accumulated Days/Hours: Sick _____ Vacation _____

Tentative End of Vacation: _____

Tentative End of 100-Day Differential: _____

Signature of Human Resource Services Representative(s)

Date

SECTION II: TO BE COMPLETED BY

