

Name \_\_\_\_\_ Department \_\_\_\_\_

 I  (was)  (will be) absent from work on the date(s) and time period(s) indicated below:

Month	Day	Year	Time of Day	Number of Hours	Reason Code*

 Employee Category: **M** = Merit, **S** = SEIU, **P** = Professional and Scientific

Employee Category	*Reason Code	Description	Employee Category	*Reason Code	Description
M,S,P	01	Vacation	M	24	Absence Without Pay
M,S,P	02	Sick Leave-Regular	M	29	FMLA Absence Without Pay
M,S,P	03	Sick Leave-Family Caregiving	M	31	Compensatory Hours Taken
M,S,P	04	Sick Leave-Funeral	M	41	Holiday Comp Hours Taken
M,S,P	05	Sick Leave-Pall Bearer/Attendant	M,S,P	51	FMLA Vacation
M,S,P	06	Sick Leave-On-The-Job Injury	M,S,P	52	FMLA Sick Leave-Regular
M,S,P	07	Sick Leave-Adoption	M,S,P	53	FMLA Sick Leave-Family Caregiving
M,S,P	10	Jury Duty	S,P	54	FMLA Workers Comp-Unpaid
M,S,P	11	Military Leave	M,S,P	55	FMLA Workers Comp-Vacation
M,S,P	12	Bone Marrow Donor	M,S,P	56	FMLA Workers Comp-Sick
M,S,P	13	FMLA Bone Marrow Donor	M,S,P	57	FMLA Sick Leave-Adoption
M,S,P	14	Vascular Organ Donor	M	58	FMLA Workers Comp-Unpaid
M,S,P	17	FMLA Vascular Organ Donor	S,P	59	FMLA Absence Without Pay

Anticipated return to work (if known): \_\_\_\_\_

 Is your absence due to: Your illness?  Yes  No

 If absence is due to your illness, did you consult with a treating health practitioner?  Yes  No

 Is the absence related to flu-like symptoms?  Yes  No

This questions is in response to current concerns about the H1N1 virus. The need for its continued use will be examined on a monthly basis. It will be discontinued once the threat is determined to have passed.

 Is your absence due to: Family member's health, medical, physical or mental condition; impairment or injury?  Yes  No

 Is your absence due to a previously designated FMLA Leave?  Yes  No

 Is your absence due to the same health condition (yours or family members) that has caused you to miss a full or partial workday earlier this calendar year?  Yes  No

Absence reported to: \_\_\_\_\_ Date reported: \_\_\_\_\_

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

 \_\_\_\_\_  
Date

 \_\_\_\_\_  
Department Head or Supervisor

 \_\_\_\_\_  
Date

 Copies to: Department  
Employee

*A department may grant sick leave, family caregiving leave, or funeral leave to an employee upon receipt of satisfactory evidence supporting the leave.*