

HEALTHY FAMILY ACT (HFA) SICK LEAVE OF ABSENCE STATEMENT

(Does not apply to bargaining unit employees)

Name: _____

Date: _____

Employment Status	Date(s) of Absence	# Hours Absent	Reason (brief explanation)
Certificated Substitute			
Classified Substitute			
Hourly Assignment			
Student Worker			

Employee signature: *I certify the above information to be correct*

Supervisor or authorized personnel signature: