OLEAN CITY SCHOOL DISTRICT
410 West Sullivan Street
Olean, NY 14760

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LONG-TERM ABSENCE REQUEST FOR PROFESSIONAL STAFF
(3 DAYS OR MORE)

Employee Name:

Leave is requested for the following date(s):

☐ AM ☐ PM ☐ FULL DAY

☐ **SICK** (Section 7.1)

☐ **FAMILY SICK** (Section 7.2 - please specify family member)

COMMENTS:

DATE: EMPLOYEE SIGNATURE:

DATE: PRINCIPAL/SUPERVISOR SIGNATURE:

DATE: SUPERINTENDENT SIGNATURE: (If Applicable) ☐ **APPROVAL** ☐ **DENIAL**

SUPERINTENDENT COMMENTS:

☐ FMLA Notification provided to employee (if applicable)

FMLA Start Date: