

CITY OF PROVIDENCE – DEPARTMENT OF PERSONNEL

REQUEST FOR ADDITIONAL PAID SICK LEAVE

SECTION A – TO BE COMPLETED BY EMPLOYEE

Employee Name: _____ Employee Number: _____

Job Title: _____ Department: _____ Home # _____ Cell # _____

I am requesting a Sick Leave Extension (Available in 30-day increments), for the following period of time:

DATE LEAVE TO BEGIN: _____

DATE OF LEAVE TO EXPIRE: _____

My reason for requesting the leave is _____

Sick Leave Extension: (1) _____ First 30 Days (2) _____ Second 30 Days (3) _____ Third 30 Days

Please Note

- 1. Sick leave extensions are granted in 30-day increments, once an employee has exhausted all of their accrued time.*
- 2. An employee is allowed 3 sick leave extensions during period of employment with the city of providence.*
- 3. All Sick Leave requests must be accompanied by a physicians/medical note, stating time employee is required to be out of work.*
- 4. All Leaves are subject to approval by department directors as well as the director of Human Resources in order to be granted.*

I understand that if I take a position with another employer or become self-employed, I will be terminated automatically.

Employee's Signature

Date

SECTION B - APPROVAL – TO BE COMPLETED BY EMPLOYER

Department Director

Date

Director of Personnel

Date