

# ABSENCE FROM DUTY REPORT

## MILES ISD

Employee Name: \_\_\_\_\_

### Employee Campus Information/Department

Please circle below

Admin    Bus    Café    Cust    Elem    JH/HS    IT    Maint

Date(s) of Absence: \_\_\_\_\_ Number of Days: \_\_\_\_\_

Physicians Statement Required for 5 or more days

### Please circle personal leave type requested

Local Personal (5 days per year, accumulative to 15 max.)

State Personal (5 days per year, accumulative)

Local Personal leave (including any accumulation) will be used first unless otherwise indicated.

### Other Leave Requested:

School Business/Staff Development \_\_\_\_\_

\_\_\_\_\_ Jury Duty (attach documents)    \_\_\_\_\_ Comp Time (Approved hourly only) \_\_\_\_\_ hours used

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

Supervisor Signature: \_\_\_\_\_

### Substitute Information

Substitute Name:

Coverage Type:

Date of Coverage:

_____	Full day / Half Day	_____
_____	Full day / Half Day	_____
_____	Full day / Half Day	_____
_____	Full day / Half Day	_____
_____	Full day / Half Day	_____

Note: **Form must be submitted immediately upon returning to duty.** A written statement from the attending physician or practitioner must be submitted for an absence of five or more continuous workdays. This statement should be attached securely hereto.

Budget Code: \_\_\_\_\_