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**