



CITY OF PROVIDENCE  
Jorge D. Elorza, Mayor

### SICK LEAVE EXTENSION REQUEST

#### 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 OF EXTENSION TO BEGIN: \_\_\_\_\_

DATE OF EXTENSION TO EXPIRE: \_\_\_\_\_

My reason for requesting the extension 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 physician's/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 Signature

\_\_\_\_\_  
Date

SECTION B - APPROVAL – TO BE COMPLETED BY EMPLOYER

\_\_\_\_\_  
Department Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director of Personnel

\_\_\_\_\_  
Date

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