

Ridgway Area School District

Professional

FAMILY SICK DAY NOTIFICATION

I hereby notify the Superintendent and Authorized Supervisor of my intention to use a **Sick Day** on _____ for the purpose of escorting an immediate family member to receive medical attention at a doctor's office, clinic or hospital.

(mark one):

Mother **Father** **Spouse** **Child** **Brother** **Sister**

NOTES:

1. A signed physician's statement will be required by the district as proof of such a visit.
Professional Employee's Policy Number 434
2. A total of two (2) sick leave days per school year shall be granted to the employee for the purpose of escorting an immediate family member to receive medical attention.
Professional Employee's Policy Number 434

Print Employee Name

Employee Signature

Date

Supervisor Signature

Date

Superintendent Signature

Date

Copies: One copy remains at the Superintendent's Office, one copy is returned to the employee and one copy to Building Principal or Head of Department

April 2011