Sacramento City Unified School District

Important: All parties, please complete and route in a timely manner.

MEMORANDUM

TO: Director
Human Resource Services

DATE: _____

FROM: _____
Human Resource Services/Workers' Compensation Office

SUBJECT: **AUTHORIZATION OF SICK LEAVE AND/OR 100-DAY DIFFERENTIAL**

Please complete Sections III and IV and return a copy of this authorization form no later than _____ to those designated on the circulated copy list. Thank you.

SECTION I: TO BE GENERATED / COMPLETED BY HUMAN RESOURCE SERVICES WHENEVER DAY-TO-DAY ABSENCE EXCEEDS BEYOND THREE (3) MONTHS OR FOR CONSECUTIVE 100-DAY GRANT REQUEST

Employee Name: _____

Social Security Number: _____

☐ Classified Employee ☐ Certificated Employee ☐ Calendar_____ ☐ FTE: _____

Payroll: _____ Location: _____

Number of Days Absent for _____ Fiscal Year as of _____ : _____
Date Days

Last Day Worked: _____

Physician's Statement(s) on File? ☐ Yes ☐ No (Attach Copies)

Number of Accumulated Days/Hours: Sick_____ Vacation_____

Tentative End of Vacation: _____

Tentative End of 100-Day Differential: _____

_____ _____
Signature of Human Resource Services Representative(s) Date

SECTION II: TO BE COMPLETED BY WORKERS' COMPENSATION OFFICE

Has Employee Filed Workers' Compensation Claim?

☐ Yes Claim Number: _____ ☐ No

Receiving Benefits at This Time? ☐ Yes ☐ No

☐ Vocational Rehabilitation ☐ Permanent Disability ☐ Temporary Disability

☐ Closed ☐ Denied ☐ Other: _____

_____ _____
Signature of Workers' Compensation Representative Date

SECTION III: TO BE COMPLETED BY HUMAN RESOURCE SERVICES

Employee Status: ☐ Day-to-Day Absence

☐ Long-Term Board-Approved Leave of Absence
Type: ☐ Health Leave of Absence ☐ Disability Leave of Absence
Effective: _____ Terminating: _____

☐ Other

_____ _____
Signature of Human Resource Services Representative(s) Date

SECTION IV: HUMAN RESOURCE SERVICES USE ONLY

☐ Place Certificated or Classified Employee on 39-Month Reemployment
Effective: _____ Through: _____

☐ Payment of Accumulated Sick Leave
☐ Approved ☐ Disapproved
Effective: _____ Through: _____

☐ Payment of 100-Day Differential
☐ Approved Differential ☐ End Differential ☐ Activate--Has Exhausted Differential
Effective: _____ Through: _____

☐ Physician's Statement
☐ Approved ☐ Disapproved Comments: _____

☐ Terminate Health Insurance
Effective: _____

_____ _____
Signature of Human Resource Services Representative(s) Date

cc: Personnel Analyst
Workers' Compensation Office
Personnel File

Distribution by:
Human Resource Services
Upon Completion of All Three Sections