

Canton City Health District**Employee Absence from Work Verification Form**

***Complete all sections of this form. Print portrait and in black and white.**

Purpose

The purpose of this form is to document employee absence from work. The employee is to complete this form within two days of the leave taken and no later than the end of the pay period for any absence from work or as soon as possible after the pay period ends. The employee's supervisor is to verify the form, sign and forward it to the Health Commissioner within two days from the date of the employee's signature.

Enter your name (last name first, then first name), date(s) absent from work from your regular work schedule and the total number of hours absent.

Employee name (last name, first name)	Date(s) absent from work	Hours absent
Stone, Joss	7/10/2015	8

If absent less than a full schedule, enter the time that you left and the time you returned. If you did not return at the end of the shift, enter your normal ending time for the shift. If absent for full schedule, enter n/a.	Time left	Time returned
	n/a	n/a

Reason absent from work (select one reason only)

- | | |
|---|---|
| <input type="checkbox"/> Illness | <input type="checkbox"/> Vacation |
| <input type="checkbox"/> Physician Appointment | <input checked="" type="checkbox"/> Personal Holiday |
| <input type="checkbox"/> Jury or Witness Duty | <input type="checkbox"/> Bereavement Leave |
| <input type="checkbox"/> Compensatory Time Used | <input type="checkbox"/> Other (explain below in the comment section) |

Comments**Was this absence related to FMLA Leave?**

- ☐ Yes
- ☒ No

FMLA - Family and Medical Leave Act

Certification

I certify that I was absent from work on the date(s) listed above and for the reason indicated on this form.

Employee Signature:	Date:
<i>Joss Stone</i>	7/2/2015

Approvals

Supervisor Signature:	Date:
<i>Jane Doe</i>	7/2/2015

Health Commissioner Signature:	Date:
<i>James Adams</i>	7/2/2015