Print Form

NON CERTIFIED SICK LEAVE FORM

NAME OF SCHOOL: _____

Pay to _____ , Social Security Number _____

Address _____

the sum of _____ dollars for _____ day(s) substitute worked at our school

for the following employee.

Number of Sick Leave Days	Date	Name of Employee	Substitute Initial	Employee Initial

Submitted By: _____

School Principal

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FOR COUNTY OFFICE USE ONLY

# of Days	Amount Per Day	Total	Fund	Function	Object