

**STATEMENT OF THE USE OF SICK LEAVE**

Please Check Type of Leave

Dept: \_\_\_\_\_

Delaware County Personnel Office  
1 Courthouse Square - Suite 2, Delhi, NY 13753  
607-746-2318 • Fax To: 607-746-6984

SELF (Employee)

FAMILY

PRE-SCHEDULED

Employee's Name (Print): \_\_\_\_\_

I hereby certify that I will use/used sick leave on the following date(s): \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_  
*If employee - enter "Self"*

Date & Time of Appointment: \_\_\_\_\_ Purpose of Visit:  Dental  Vision  Medical

The Employee was unable to work due to illness (self or family member) on the above indicated dates.

*(Attach Other Supporting Documentation to Form)*

Employee will be able to return to work:  Immediately **OR**  Not before this Date: \_\_\_\_\_  
 Unable to Work From: \_\_\_\_\_ Until: \_\_\_\_\_

**AND**

With No Restrictions **OR**

With the Following Restrictions: \_\_\_\_\_

Notes

Health Care Provider Signature or Stamp: \_\_\_\_\_ Date: \_\_\_\_\_

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