FORM: SLUNI 10/28

# STATEMENT OF THE USE OF SICK LEAVE

Delaware County Personnel Office
1 Courthouse Square - Suite 2, Delhi, NY 13753
607-832-5678 • Fax To: 607-832-6044

Please Check Type of Leave
- ☐ SELF (Employee)
- ☐ FAMILY
- ☐ PRE-SCHEDULED

Dept:_____

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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