



RIVERSIDE COUNTY
OFFICE OF EDUCATION

Division of Administration and Business Services

Request/Verification of Attendance

Please refer to appropriate Employee Handbook/Agreement for explanation of leave benefits.

Name: _____ ☐ Request ☐ Verification of Leave

Date(s): _____ If partial day from: _____ a.m./p.m. to: _____ a.m./p.m.

☐ **Personal Illness (Sick Leave)**

☐ FMLA/CFRA (Requires approval from Personnel)

☐ **Illness of a Qualifying Family Member**

(Limited to amount of sick leave accrued in six months per fiscal year)

Relationship: _____

☐ FMLA/CFRA (Requires approval from Personnel)

☐ **Personal Necessity** (Requires advance notice, if feasible.)

☐ Extension of Bereavement

☐ Accident involving person or property

☐ Court Appearance as litigant, party or witness under subpoena

☐ Official School & Licensed Child Care Activities for Dependent Children (40 hours/fiscal year, 8 hours/month)

☐ Other: (Impending death/critical illness of family member; religious holiday; property protection such as fire, flood; paternity/adoption; conditions beyond control of employee)

☐ **Personal Business** (Requires prior approval, if feasible)

☐ **Baby Bonding Leave** (Requires approval from Personnel)

☐ **Vacation** (Requires advance approval)

☐ **Compensatory Time** (Requires advance approval)

☐ **Birthday Leave** (CSEA unit)

☐ **Non-Duty** (MANAGEMENT only)

☐ **Bereavement/Funeral Leave**

Name: _____

Relationship: _____

Location: _____

☐ **Jury Duty** (Attach verification of attendance)

☐ **Military Leave** (Attach copy of orders)

☐ **Industrial Accident Leave**
(Requires approval from Risk Management)

Date of Injury: _____

☐ **Other:** (Indicate reason under remarks below)

Overtime/Compensatory Time* Request

Authorization is requested for overtime for the above named employee during the following days/times:

Day	Date	Hours	Day	Date	Hours	Fund	School	Resource	Year	Goal	Function	Object	%

Reasons why task(s) cannot be completed without overtime: _____

Maximum number of **hours** requested: _____ ☐ Compensatory Time ☐ Regularly Paid Overtime

Employee: _____ Date: _____

☐ Approved ☐ Disapproved Supervisor: _____ Date: _____

Remarks: _____

☐ Approved ☐ Disapproved Director: _____ Date: _____

Remarks: _____

Overtime Worked

Employee Signature: _____ Date: _____ Supervisor Signature: _____ Date: _____