



# Employee Absentee Record

☒ Hourly Employee ☐ Salary Employee

Name \_\_\_\_\_ Employee ID # \_\_\_\_\_ Department \_\_\_\_\_

Absent from: \_\_\_\_\_ to: \_\_\_\_\_  
Date Time Date Time

Absent for: \_\_\_\_\_ Days and \_\_\_\_\_ Hours

## PAID TIME OFF

☐ Sick (doctor's note required for 3 or more consecutive days)  
(Use Sick Balance)

☐ Vacation  
(Use Vacation Balance)

☐ Bereavement (3 days allowed, indicate how related)

☐ Jury Duty (See HR for detail)

☐ Workers Comp Appointment  
(Only for the time missed on the day of injury and the medical exam required by Workers Comp Insurance co., not any other follow-up office visit.)

## SPECIAL CIRCUMSTANCES

(Need HR Verification)

☐ Leave of Absence / FMLA

☐ Workers Comp Leave

☐ Unpaid Time Off (only for special circumstances & emergencies, after all sick/vacations been exhausted)

Please provide appropriate detail (optional):

\_\_\_\_\_  
Employee Signature / Date Time

\_\_\_\_\_  
Substitute Signature / Date Time

\_\_\_\_\_  
First Level Approver Signature / Date Time

\_\_\_\_\_  
\* Second Level Approver Signature / Date Time

\_\_\_\_\_  
\*\* FINAL Approval / Date Time

\* Second Level Supervisor approval needed for 4 or more days of absence

\*\* All positions Director level and above must obtain FINAL approval for 3 or more days absence. (Positions below Director level are NOT required to obtain FINAL approval.)

\*\*\* For absence longer than 2 weeks, please complete SM Form #216 (Return to Work Form) *after* you return.