



**Haverhill Public Schools
School Health Services**

Time Off Request Form

Name: _____ Date Submitted: _____

Date(s)/Time Requested: _____

Type of Time Off Requested:

_____ **Personal Time*** (full time nurses are allowed 3 personal days per academic year(July-June), pro-rated based on FTE status)

_____ **Medical/Sick time** (see contract re rules related to use of sick time for serious illness of spouse, child or parent)

_____ **Professional Development** (must be pre-approved)

Provide course name, value to district, etc.: _____

_____ **Jury Duty**

_____ **Vacation**

_____ **Other**

Send requests to Director of Health and Nursing Services.

_____ **Approved**

_____ **Denied**

Signature: _____ Date Received: _____