CANASTOTA CENTRAL SCHOOLS

Leave Request Form for COVID-19 Vaccination

Please Print

Name: _____ Title: _____

Date Submitted: _____ Department: _____

Regular Hours of Employment

Date and Time of Vaccination Appointment:

Date: _____ Time _____

*Leave Requested

From _____ a.m./p.m. To _____ a.m./p.m.

*This time must not exceed four (4) hours. If leave time exceeds four (4) hours, the District Attendance Office will use any accrued available time, either sick, compensatory, personal or vacation, in that order to ensure that an employee does not lose pay for any portion of the day .If no accrued time is available for use, pay for the day will be limited to four (4) hours.

Instructions:

A leave form must be completed for each instance of leave requested. Once you have completed this form and turned it in to your supervisor, and in order to receive paid leave, you must also complete and return the attached "Verification of COVID-19 Vaccination Appointment" form for each instance, to Human Resources.

Form turned in to Supervisor:

Supervisors: Please send a copy of this completed and signed form to Human Resources upon receipt from employee.

Supervisor Signature: _____ Date: _____

Verification of COVID-19 Vaccination Appointment

(Return completed form and any attachments to Human Resources)

Instructions: This form must be signed by a representative of the facility providing the vaccination, on the date of your appointment. You may make a copy of your vaccination card and attach it, however, this form must still be signed by a facility representative. Should the facility provide its own verification letter or form, you may attach that, as well.

TO BE COMPLETED BY EMPLOYEE:

Employee Name _____

Date of Birth _____

Address _____

Telephone Number _____

This is to verify that I appeared:

At: _____(Name of Facility) On:

_____(Date)

At: _____(Time)

For the purpose of receiving the following for the COVID-19 vaccination:

First injection of a two dose vaccine (i.e. Moderna, Pfizer)

Second injection of a two dose vaccine (i.e. Moderna, Pfizer)

Single injection vaccine (i.e. Johnson & Johnson)

Booster

To be completed by a representative of the vaccinating facility:

Printed Name_____

Signature _____

Contact Telephone_____