RESET FORM

CHABOT-LAS POSITAS COMMUNITY COLLEGE DISTRICT

CLASSIFIED EMPLOYEES MONTHLY TIME AND SERVICE REPORT

EMPLOYEE NAME _____ **W#** _____ **Mo/Yr** _____ **to Mo/Yr** _____

Do not use SSN

READ INSTRUCTIONS ON BACK BEFORE COMPLETING THIS FORM

List any hours of absence for each working day:

Date	Hours Absent	Absent Code	Date	Hours Absent	Absence Code
16			1		
17			2		
18			3		
19			4		
20			5		
21			6		
22			7		
23			8		
24			9		
25			10		
26			11		
27			12		
28			13		
29			14		
30			15		
31					

ABSENCE CODE

Indicate in column marked "Absence Code" the correct letter.

S	Illness or Injury
SC	On-the-job injury
E	Personal Necessity Leave
B	Bereavement Leave
C	Required Jury Duty/Court Appearance
M	Military Leave
A	Authorized Board Absence
V	Vacation
H	Holiday
FH	Floating Holiday
W	Leave Without Pay
U	Unauthorized Leave Without Pay
R	Release Time
F	Furlough Days
	Must be taken in 4 or 8 hour increments
CTT	Comp Time Taken
PPT	Premium (Pay) Leave Taken

PLEASE CHECK SERVICE ASSIGNMENT:

☐ Chabot ☐ Las Positas DISTRICT: ☐ Hayward ☐ Livermore ☐ Dublin

MEDICAL STATEMENT: A unit member who claims sick leave for three (3) or more consecutive days or five (5) cumulative days within any thirty (30) calendar day period, or if the District has reason to believe that the unit member is not legitimately entitled to claim sick leave may be required to present a written, signed statement on a District-approved form from a medical doctor, or from the unit member's religious advisor where such is deemed in conformance with religious tenets, verifying the nature of the illness, injury or quarantine, inclusive dates when the employee is unable to work because of medical condition and the date the employee can return to work. A similar statement may be required by the District in any cases where an absence claimed to be due to illness or injury must be verified. Employees returning to work after serious illness may be required to provide medical evidence of recovery sufficient to assume regular duties.

I certify this to be a true and accurate record of hours worked.

Employee signature _____ Date _____

Manager/Supervisor signature _____ Date _____

Comment(s): _____