

MONTHLY ABSENCE RECORD

NAME _____

ID NUMBER _____

DEPT. NO. & SUFFIX _____

LEGEND:

V - Vacation Hours
 C - Court Leave Hours
 P - Personal Hours
 N - Non-Paid Hours

DISABILITY:

E - Employee Hours
 F - Family Hours

I HEREBY CERTIFY THIS REPORT TO BE A TRUE AND ACCURATE RECORD OF MY ABSENCES DURING THIS MONTH.

SIGNATURE OF EMPLOYEE: _____

SIGNATURE OF SUPERVISOR: _____

INSTRUCTIONS:

1. Report absences, net of time made up for dates indicated.
2. Determine the total net hours absent each day and enter the total net hours and type of absence in the appropriate week day column, rounded to the nearest quarter hours.
3. Add the hours shown by each day and record the total of each week rounded to the nearest quarter hours. The sum of all daily absences MUST equal the weekly total.
4. Total the hours by type absence and record the total in columns V, C, E, F, P, N and Total Hours Absent in Summary of Absences.
5. Form must be signed by employee and supervisor.
6. Forms should be maintained in the departmental files.

SUMMARY OF ABSENCES								
	V	C	DISABILITY		P	N	=	TOTAL HOURS ABSENT
			E	F				
TOTALS FOR MONTH								

REPORTING PERIOD:

	SUN	MON	TUES	WEDS	THUR	FRI	SAT	HOURS ABSENT
1ST WEEK								
REASON CODE								
2ND WEEK								
REASON CODE								
3RD WEEK								
REASON CODE								
4TH WEEK								
REASON CODE								
5TH WEEK								
REASON CODE								
TOTAL HOURS ABSENT								

BAYLOR UNIVERSITY MONTHLY ABSENCE RECORD

For payment of Employee or Family Disability Leave, complete the Application For Disability Leave Payment.

APPLICATION FOR DISABILITY LEAVE PAYMENT

Application is due to disability of: Empl _____ Spouse _____ Dependent Child _____

Other (Name and Relationship) _____

Nature of disability: _____

A STATEMENT FROM THE ATTENDING DOCTOR IS REQUIRED OF EMPLOYEES APPLYING FOR MORE THAN THREE CONSECUTIVE DAYS OF DISABILITY LEAVE FOR THEMSELVES OR ANY OTHER ELIGIBLE FAMILY MEMBER.

Funeral:

Name of Deceased: _____ Relationship: _____

Date of Funeral: _____ City: _____

I hereby authorize all doctors presently involved or who become involved in consultation and/or treatment of me or my eligible family members for the above named disability to release all information regarding said disability to Baylor University, with the understanding that Baylor University will not release or publish such information except to the extent necessary in determining the validity of this claim for disability leave. I also hereby certify that all the above statements are true and correct.

Signature of Employee

Date

Signature of Supervisor

Date