1. TO BE COMPLETED BY EMPLOYEE, PRINT OR TYPE:

<table>
<tr><td colspan="2">Last Name</td><td colspan="2">First Name</td><td colspan="2">Initial</td><td colspan="2">Employee ID #</td></tr>
<tr><td colspan="3">Home Address</td><td colspan="2">City</td><td>State</td><td>Zip</td><td>Home Telephone</td></tr>
<tr><td colspan="3">Position</td><td colspan="3">Work Location/Supervisor's Name</td><td colspan="2">☐ Classified
☐ Faculty
☐ Management Team</td></tr>
<tr><td colspan="3">Dates of Leavev</td><td colspan="4">Employee Signature</td><td>Date</td></tr>
</table>

2. TO BE COMPLETED BY ATTENDING PHYSICIAN:

<table>
<tr><td colspan="4">By signing this form, you are certifying that the employee is unable to work.</td></tr>
<tr><td colspan="4">Estimated date employee will be able to return to work:</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2">Physician Name (Print or Type)</td><td>Physician Signature</td><td>Date</td></tr>
<tr><td>Office Address</td><td></td><td>Office Telephone</td><td></td></tr>
<tr><td colspan="4">**Give to patient or mail to: Payroll Department, Long Beach City College, 4901 E. Carson Street, Long Beach, CA 90808</td></tr>
</table>

3. PAYROLL DEPARTMENT

Sick Leave Ends mm/dd /yy

StatutoryEnds 7