

Name: _____

Date: _____

SUBSTITUTE NEEDED: Yes No

If Yes:

DATES OF LEAVE:

Full Day

From (dates) _____ to _____

½ Day

TIME: _____ to _____

<input type="checkbox"/>	B	Bereavement
<input type="checkbox"/>	C	Conference
<input type="checkbox"/>	F	Field Trip
<input type="checkbox"/>	J	Jury Duty
<input type="checkbox"/>	M	Meeting
<input type="checkbox"/>	P	Personal
<input type="checkbox"/>	FS	Family Sick
<input type="checkbox"/>	S	Sick
<input type="checkbox"/>	V	Vacation
<input type="checkbox"/>	O	Other

If you have checked a shaded area, you must complete this section:

Description of Leave:

Location: _____

Signature: _____

THIS IS JUST AN ESTIMATE of how much the conference will cost. To be reimbursed for expenses incurred, a claim voucher must be submitted with itemize4d receipts.
TIPS and ALCOHOLIC BEVERAGES ARE NOT REIMBURSABLE, SALES TAX is included.

ESTIMATED COST of CONFERENCE:	AMOUNT
Registration ** Fee:	
Accommodations:	
Meals:	
Travel:	
Other costs (be specific):	
TOTAL ESTIMATED COST	
SUBSTITUTE COST	

General Fund
 Title I
 Title II
 Special ED
 BOCES

APPROPRIATE SIGNATURE:

PRINCIPAL: _____

APPROVED

DENIED

SUPERINTENDENT: _____

LEAVE w/o PAY

FOR OFFICE USE ONLY:		
FUND NAME	CODE	Amount

CC: SUPERINTENDENT PRINCIPAL BUSINESS OFFICE REQUESTOR GRANT COORDINATOR