FORT EDWARD UFSD **REQUEST FOR LEAVE**

Name: _____ Date: _____

SUBSTITUTE NEEDED: Yes ☐ No ■
If Yes:

From (dates) _____ to _____

TIME: _____ to _____

DATES OF LEAVE: Full Day ■

_____

½ Day ☐

☐	B	Bereavement
☐	C	Conference
☐	F	Field Trip
☐	J	Jury Duty
☐	M	Meeting
☐	P	Personal
☐	FS	Family Sick
☐	S	Sick
x	V	Vacation
☐	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: _____

SUPERINTENDENT: _____

APPROVED ☐
DENIED ☐
LEAVE w/o PAY ☐

FOR OFFICE USE ONLY:

FUND NAME	CODE	Amount

CC: SUPERINTENDENT ☐ PRINCIPAL ☐ BUSINESS OFFICE ■ REQUESTOR ☐ GRANT COORDINATOR ☐