SOUTH colonie CENTRAL SCHOOLS

District Office
102 Loralee Drive
Albany, NY 12205
(518) 869-3576

CHILD CARE ACTION FORM

To be completed by employee:

Name: _____ Date Hired: _____

Address: _____

_____

Phone: (_____ Grade/Subject: _____

Social Security #: XXX-XX- _____ School: _____

Expected Delivery Date: _____

Actual Delivery Date: _____

_____ I will not exhaust sick leave

_____ I will exhaust sick leave

I plan to return after my 30 to 40 days term of disability. _____ Yes _____ No

I plan to take an unpaid leave of absence. _____ Yes _____ No

I plan to return September: January: Other:

_____ _____

(Teacher Signature) (Date)

(Please retain a copy and return the signed original as soon as possible. If you have any questions, please contact the Human Resource Department.)