FORM 97.03 R10/07

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

MONTHLY ABSENCE REPORT

Section I — EMPLOYEE IDENTIFICATION

Employee Name_____
Last First MI

Social Security #: (Last four digits only) _____ For the Month Ending_____ _____

Cost Center Name_____ Cost Center Number_____

Section II — DATA SUMMARY H0BUA

Vacation Hours	___ . ___
Sick Hours	___ . ___
UCMC Holiday Hours	___ . ___
Personal Holiday Hours	___ . ___

Section III — SALARY REDUCTION HUE01

(Salary is to be reduced for full day absences only.)

Code 964 Unpaid Hours ___ . ___ Hours

Section IV — DETAIL OF ABSENCES

Please Indicate: ☐ No absences during month ☐ Absences as detailed below

Date	Hours Absent	Explanation of Absence	Reduce Salary Full Day Absences Only No	Yes

Section V — EMPLOYEE AND DEPARTMENTAL SIGNATURES

This is a complete record of my absences, if any, for the period indicated.

_____ _____
Signature of Employee *Date*

Approved by _____ _____
Signature of Immediate Supervisor *Date*