COPY

SAN JOAQUIN COUNTY MOSQUITO AND VECTOR CONTROL DISTRICT
TIME OFF RECORD SHEET

DATE: 7-25-11 NAME: Tiffany Anderson Emp. #: 306

It is requested that time off on 7-26-11

consisting of ______ day(s) 1.5 hour (s) working time, be approved.

This time off be charged to:

off @ 2:00

		For Office use only
Vacation	✓ 1.5	______ Vac
Sick Leave	______	______ Sick
Sick Leave due to family illness	______	______ F.Sick
		______ Comp.Off
		______ W/C Off

I used or wish to use ______ days or ______ hours of accrued and available sick leave to care for an ill family member. The sick leave was or will be used on ____________________.

The family member is my ____________________.

Compensation for overtime	______
Time off without pay	______
Workers' comp. time off	~~X~~
Jury Duty	______
Bereavement Leave 1	______
Bereavement Leave 2	______

(Emps': aunt, uncle, niece nephew, charged to sick leave)

[signature]
Employees' Signature

Date: 8-1-11

[signature]
Immediate Supervisor's Signature

COPY

Alpine Orthopaedic Medical Group, Inc.
ORTHOPAEDIC SURGERY

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2488 N. CALIFORNIA ST. STOCKTON, CA 95204 (209) 948-3333

DATE 7/2/11

It is my medical opinion that DOI

Tiffany Anderson

is capable of resuming the activities of his/her occupation as described below:

WORK STATUS:

- [x] Regular work
- [ ] Modified work with limitations noted
- [ ] Unable to return to work until

Date:

WORK LIMITATION:

(✓) = partial capacity

(x) = no capacity

- [ ] Bending
- [ ] Reaching
- [ ] Lifting
- [ ] Climbing
- [ ] Standing
- ______ lbs.
- [ ] Pulling
- [ ] Pushing
- [ ] Sitting

_______________ M.D.