



LEAVE FORM

Employee Name: _____ Department _____

TO BE COMPLETED BY EMPLOYEE:

Type of leave requested:

- Annual Leave (12 month employees only)
- Personal Leave (9-11 month employees only)
- Sick Leave (**For absences of 3 or more consecutive days, a physician's release to return to work is required**)
- Workers' Compensation Leave
(Is this absence due to work related illness or injury? If yes, have you forwarded an Incident Report to HR? If no, please attach the Incident Report)
- Administrative Leave (Event documentation must be attached)
- Bereavement (3 days for immediate family; documentation must be attached)
- Leave Without Pay (For unpaid leave, please briefly state reason)

Comments: _____

DATES INVOLVED: (Only enter actual dates of absenteeism)

Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____
Date: _____	Number of Hours: _____

Total number of **hours**: _____ Total number of **days**: _____

I understand that if I have no leave on the books, my wages may be adjusted accordingly.

Employee Signature: _____ Date: _____

Supervisor/Manager Signature: _____ Approved ___ Denied ___ Date: _____

Department Head Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE. FOR HR USE ONLY

Entered by: _____ Date: _____