REQUEST FOR LEAVE

Name:_____ SSN:_____

Department:_____ Date:_____

Type of Request: (requested leave must include time and date)

Vacation (____hours) Starting _____ Ending _____
Time Date Time Date

(____hours) Starting _____ Ending _____
Time Date Time Date

Sick Leave* (____hours) Starting _____ Ending _____
Time Date Time Date

(____hours) Starting _____ Ending _____
Time Date Time Date

*Sick leave may be taken for illness, injury, exposure to contagious disease and medical, dental or optical appointments for the employee and/or the employee's immediate family. Immediate family shall consist of the employee's spouse or children, employee's or spouse's parents, brother, sister, grandparents or grandchildren.

Other (____hours) Starting _____ Ending _____
Time Date Time Date

Specify type _____ (Personal, Death, Jury Duty, Military, Without Pay)

Employee Signature: _____ Date: _____

Title: _____

Approved by: _____ Date:_____

Fill out form completely, sign and date (both employee and department head). Keep a copy for your record and return original with payroll sheets.