REQUEST FOR LEAVE

Name (Print) Last _____ First _____ Middle Initial _____ Date _____

Employing Unit _____

I Request Leave Beginning _____ ☐ AM ☐ PM Date _____ and Ending

_____ ☐ AM ☐ PM Date _____ For the Following Reason:

Check One:

☐ Medical, Dental, or Optical Examination or Treatment

☐ Personal Illness or Injury _____

☐ Serious Illness or Injury in Immediate Family _____

☐ Death of _____ on _____

☐ Vacation

☐ Court: ☐ Court Duty ☐ Jury Duty Subpoena Issued _____ Court

Date _____

☐ Military ☐ With Pay ☐ Without Pay

☐ Leave Without Pay

☐ Comp Time

☐ Personal Leave

☐ Other (Explain) _____

_____ _____

Total Hours Requested Signature of Employee

Physician's Statement

AS A DULY QUALIFIED PRACTITIONER OF MEDICINE, I CERTIFY THAT THE USE OF SICK LEAVE DESCRIBED ABOVE IS JUSTIFIED, IN MY OPINION. THE PERSON INVOLVED WAS UNDER MY PROFESSIONAL CARE FOR THE ABOVE STATED PERIOD AND IS MEDICALLY CAPABLE TO RETURN TO WORK.

_____ _____

Date Signature of Physician

_____

Address

_____

City State Zip

Administrative Action

☐ Recommended ☐ Approved ☐ Subject to FMLA

☐ Not Recommended ☐ Disapproved ☐ Yes ☐ No

_____ _____

Supervisor Date Appointing Authority Date

Remarks _____

Make 2 Copies after final approval to be distributed to the following:

Payroll - Original **Employee** **Employee's Dept.**