



LEAVE REQUEST FORM

Date: _____ Department: _____ PP#: _____

Employee Name: _____

Type of Leave: Annual Sick Funeral Compensatory Time LWOP (Leave Without Pay)
 Jury/Witness Extended Medical Military Non-Medical Extended LWOP (Leave Without Pay)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date:							
Hours:							

Note:

- Directors may request a doctor's statement for sick leave at his/her discretion.
- Extended Medical Leave requires medical certifications supporting the need for leave due to a serious health condition affecting the employee or an immediate family member.

Leave Balances	Annual	Sick	Comptime
Beg. Balance			
Leave Accrued			
Leave Used			
Ending Balance			

Employee Signature Date

*****SUPERVISOR APPROVAL*****

Approved Disapproved

Supervisor Signature Date

Explanation for Disapproved leave: _____