# 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:
1. Directors may request a doctor's statement for sick leave at his/her discretion.

2. 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.

_____
Employee Signature Date

## SUPERVISOR APPROVAL

____Approved ___Disapproved

Comments:_____

_____
Supervisor Signature Date