



APPLICATION FOR LEAVE

NAME: _____ DATE: _____

DEPARTMENT: _____ S.S.#: _____

Date(s)									Hours	Week Ending
Type of Leave										
Vacation*										
Sick Personal**										
Sick-Family**										
Personal										
Comp. Time***										
LWOP										
Other										

**Vacation must not exceed amount available. While on vacation, do you want to be considered for call in?
Yes _____ No _____

**Reason for Sick Leave _____

(Certification of a physician or practitioner may be required)

***Indicate dates Compensatory Time earned: _____

***If Other, please check: Jury Duty____ Military____ Fam. Med. Leave____ Injury Leave____ Birthday____

Comments: _____

Employee Signature Date

Approved

Denied (explanation: _____) Immediate Supervisor Date

Approved

Denied (explanation: _____) Department Head Date