LEAVE REQUEST FORM

Name:_____ Date:_____

Department:_____ Title:_____

VACATION LEAVE
Date(s)Requested: From:_____through_____Hours_____

SICK LEAVE
Date(s)Requested: From:_____through_____Hours_____

OTHER LEAVE
Date(s) Requested: From through_____Hours_____

Type of Leave: ☐With Pay ☐Without Pay

Family and Medical Leave Act: ☐Yes ☐No

_____ _____
Employee Signature **Date**

SUPERVISOR ACTION

☐Approved ☐Denied

_____
Supervisor's Signature

_____
Date

Appendix E
Form 11