LEAVE REQUEST FORM

Employee Name: ______________________________ Date: ______________________________

Department: __________________________________ Job Title: ______________________________

☐ Vacation Leave ☐ Sick Leave ☐ Comp Time ☐ Other Leave Type: _________________

Family and Medical Leave Act: ☐ Yes ☐ No

Date(s) Requested From: _________________ through __________________ Hours _________

Comments: ____

☐ Vacation Leave ☐ Sick Leave ☐ Comp Time ☐ Other Leave Type: _________________

Family and Medical Leave Act: ☐ Yes ☐ No

Date(s) Requested From: _________________ through __________________ Hours _________

Comments: ____

☐ Vacation Leave ☐ Sick Leave ☐ Comp Time ☐ Other Leave Type: _________________

Family and Medical Leave Act: ☐ Yes ☐ No

Date(s) Requested From: _________________ through __________________ Hours _________

Comments: ____

☐ Vacation Leave ☐ Sick Leave ☐ Comp Time ☐ Other Leave Type: _________________

Family and Medical Leave Act: ☐ Yes ☐ No

Date(s) Requested From: _________________ through __________________ Hours _________

Comments: ____

__________________________________ ____________________

Employee Signature Date

SUPERVISOR ACTION

Leave Request is Approved Denied

__________________________________ ____________________

Supervisor/Manager Signature Date