

TOTAL HOURS

LAST NAME (Please Print)	FIRST	M.I.	DEPARTMENT	DATE
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I REQUEST LEAVE BEGINNING \_\_\_\_\_ AM/PM \_\_\_\_\_, 20\_\_\_\_, AND ENDING \_\_\_\_\_ AM/PM \_\_\_\_\_, 20\_\_\_\_, FOR THE FOLLOWING REASONS:

SICK LEAVE: \_\_\_\_\_ ILLNESS / INJURY

FMLA: \_\_\_\_\_

Nature: \_\_\_\_\_

\_\_\_\_\_ Self \_\_\_\_\_ Immediate Family

(If immediate family) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

If Employee illness/injury, was it job related? \_\_\_\_ Yes \_\_\_\_ No

If Yes, date of occurrence: \_\_\_\_\_

Was claim filed with Workers' Compensation?

\_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_ VACATION \_\_\_\_\_ COMPENSATORY TIME USED

\_\_\_\_\_ LEAVE WITHOUT PAY (Reason) \_\_\_\_\_

\_\_\_\_\_ PERSONAL DAY

\_\_\_\_\_ LEGAL LEAVE: \_\_\_\_\_ Court Duty \_\_\_\_\_ Jury Duty

\_\_\_\_\_ MILITARY LEAVE: \_\_\_\_\_ With Pay \_\_\_\_\_ Without Pay

\_\_\_\_\_ UNION LEAVE: \_\_\_\_\_ With Pay \_\_\_\_\_ Without Pay

\_\_\_\_\_ Recommended

\_\_\_\_\_ Not Recommended

\_\_\_\_\_  
Supervisor / Dept. Head \_\_\_\_\_ Date

\_\_\_\_\_ MEDICAL/DENTAL/OPTICAL EXAM/TREATMENT

\_\_\_\_\_ Self \_\_\_\_\_ Immediate Family

(If immediate family) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

**PRACTITIONER'S STATEMENT:**

As a duly qualified medical (or medical-related) practitioner, I certify that the use of sick leave described above is justified, in my opinion. The person involved was under my professional care for the above-stated period.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip

**DEATH IN IMMEDIATE FAMILY**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship \_\_\_\_\_ / \_\_\_\_\_ Date

\_\_\_\_\_  
**EMPLOYEE SIGNATURE** \_\_\_\_\_ **DATE**

Human Resources disposition:

\_\_\_\_\_ Approved \_\_\_\_\_ Not Approved

\_\_\_\_\_  
HR Representative \_\_\_\_\_ Date

REMARKS: \_\_\_\_\_

\_\_\_\_\_