



LEAVE REQUEST FORM

Employee Identification # _____ Date _____

Employee Name _____ Department _____

Annual Leave _____

Period Absent:

Date Beginning	Date Ending	Total Hours
_____	_____	_____

This may be used in one-quarter (1/4) hour increments.

Sick Leave _____

Period Absent:

Date Beginning	Date Ending	Total Hours
_____	_____	_____

This may be used in one-quarter (1/4) hour increments.

Please choose one of the following:

- | | |
|--|--|
| <input type="checkbox"/> Sick | <input type="checkbox"/> Sick Relative |
| <input type="checkbox"/> Doctor Appointment | <input type="checkbox"/> Death in Family |
| <input type="checkbox"/> Dentist Appointment | <input type="checkbox"/> Miscellaneous |

Comments: _____

If leave extends into next month, an additional form must be used.

SIGNED _____	SIGNED _____
Employee Signature	Immediate Supervisor Signature
Date	Date