LEAVE OF ABSENCE FORM

Employee Name:	
Department:	Date:

TYPE OF LEAVE

☐ Military ☐ Medical* ☐ Personal ☐ Other _____

** Medical certification from a health care provider will be required if the leave is approved.*

First day off: Day: _____ Date: _____

To and including: Day: _____ Date: _____

Total number of days off requested: _____

I will return to work on: Day: _____ Date: _____

Explanation/comments:

Employee Signature:	Date:

APPROVALS

Request for Leave is: ( ) Approved

( ) Denied

If request is denied, reason:

Employee's Signature:	Date:
Supervisor's Signature:	Date: