INSTRUCTIONS: Staff member complete form, obtains supervisor's signature, and forwards form to Human Resources. The Human Resources Office will notify the supervisor and staff member if the application is not approved.

NAME_____ DATE_____

DEPARTMENT_____ TITLE_____

Type of Leave: Annual ☐ Sick ☐ Compensatory ☐ Other ☐

Date(s) Day(s)/Hour(s)

_____

_____

_____

_____

For Sick Leave:

I certify that this absence was due to:

☐ Illness which prevented my working

☐ Medical, dental, or optical treatment by _____
Doctor's Name

☐ A Medical or Dental note is attached

Note: A Physician's note is required for: (1) illness extending for more than three consecutive working days and (2) each month in the case of prolonged illness.

Any authorized leave that is found to be in excess of the staff member's leave balances will be without pay. Except in emergency situations annual leave must be approved in advance by the staff member's supervisor. Failure to file this form with the Human Resources Office may result in a charge to leave without pay.

_____
Signature of Employee

Approved: _____
Supervisor

Approved: _____
Human Resources Officer

/kg/ann.sic
Revised 10/06