

# Sam Houston State University Human Resources

## Leave Request/Approval Form

Employees must complete this form in advance for leaves and other absence from duty. This form should be complete with the type of leave, dates of absence, number of hours requested, and required documentation attached before it is forwarded through the administrative channels for approval. Please check Banner Self-Service (SSB) on MySam for your leave balances. If you are still unsure of your current leave balances, please contact Payroll. Employees must complete a Leave Report or Time Sheet to reflect the hours actually taken for the appropriate pay period and submit to Payroll for processing.

Name: \_\_\_\_\_ Sam ID: \_\_\_\_\_  
Address: \_\_\_\_\_ Home/Cell#: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Department: \_\_\_\_\_  
Supervisor Name: \_\_\_\_\_ Supervisor Phone #: \_\_\_\_\_

### Leave Categories:

\_\_\_\_\_\*Administrative Performance Leave  
\_\_\_\_\_\*Bereavement Name/Relationship: \_\_\_\_\_, date occurred: \_\_\_\_\_  
\_\_\_\_\_\*Blood Donation \_\_\_\_\_\*Certified Red Cross Activities \_\_\_\_\_\*Emergency  
\_\_\_\_\_\*Foster Parent Leave \_\_\_\_\_\*Jury Duty/Witness \_\_\_\_\_\*Leave Without Pay  
\_\_\_\_\_\*Military \_\_\_\_\_\*Organ/Bone Marrow Donor \_\_\_\_\_\*Parent/Teacher Conference Leave  
\_\_\_\_\_\*Sick ☐ Self ☐ Family Name/Relationship of Family Member: \_\_\_\_\_  
Does this apply to FMLA/Parental Leave? ☐ Yes ☐ No  
If yes, does your Spouse work for a Texas State Agency? ☐ Yes ☐ No If yes, what Agency? \_\_\_\_\_  
\_\_\_\_\_\*Training for Disability \_\_\_\_\_Vacation \_\_\_\_\_Voting

*\*Attach supporting documentation. \*\*Sick Leave absences for more than 3 consecutive days requires medical certification. Refer to Human Resources Policy B-1, Employee Leaves, for additional details and information about eligibility and usage.*

Type of Leave Requested:	Dates of Absence:	# of hours:
_____	____/____/____ - ____/____/____	_____ hours
_____	____/____/____ - ____/____/____	_____ hours
_____	____/____/____ - ____/____/____	_____ hours
_____	____/____/____ - ____/____/____	_____ hours

Completed medical certification (if applicable): ☐ Was submitted to Human Resources. ☐ Will be submitted to Human Resources.  
☐ Check here if **Other Assigned Duty Point Work Arrangement** will be requested\*\*\*  
☐ Check here if leave is in conjunction with the **SHSU Worker's Compensation Return-To-Work Program**.

\*\*\*Approval must be received from the Department Head, Associate Vice President for Human Resources and Risk Management, and Divisional Vice President.

### Employee Acknowledgement & Signature

I certify that the information above is accurate. I understand I will need to notify my supervisor, department, and/or Human Resources immediately should the status of my leave change. I understand it is my responsibility to submit all proper documents regarding this request. If I am not able to return the required documentation within the allowed timeframe, I will contact Human Resources for assistance. My anticipated return to work date will occur on \_\_\_\_\_.

Employee: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Supervisor Approval:

As the supervisor of the employee listed above, I am aware that the employee has applied for leave as indicated above. I will notify Human Resources immediately if I become aware of any changes to the information provided.

Supervisor: \_\_\_\_\_ ☐ Approved ☐ Disapproved Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Administrative Approvals:

Dept. Head/Chair: \_\_\_\_\_ ☐ Approved ☐ Disapproved Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dean (if applicable): \_\_\_\_\_ ☐ Approved ☐ Disapproved Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Vice President: \_\_\_\_\_ ☐ Approved ☐ Disapproved Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Human Resources: \_\_\_\_\_ ☐ Approved ☐ Disapproved Date \_\_\_\_/\_\_\_\_/\_\_\_\_

President: \_\_\_\_\_ ☐ Approved ☐ Disapproved Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Administrative Performance /Emergency Leave only)

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_