

State of Ohio
Request For Leave

Name	(Last)	(First)	(Middle Initial)	Date
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Employing Unit _____

I request leave
 Beginning _____ (time) A. M. P. M. _____ (date), _____ (year), and
 Ending _____ (time) A. M. P. M. _____ (date), _____ (year), for the following reason:

Mark Appropriate Boxes Below:

Sick Leave # of Hours _____ (Explain)

Vacation # of Hours _____ Personal # of Hours _____ Compensatory # of Hours _____

Leave Without Pay (Explain)

<input type="checkbox"/> Bereavement	Name of Deceased	Relationship	Date of death
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(Attach copy of subpoena or summons)

Jury Duty Witness Duty

(Attach copy of orders, or other appropriate documentation, that supports request for Military leave)

Military With Pay Military Without Pay

<input type="checkbox"/> Adoption / Childbirth Leave	Event Date	Do you wish to supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> Pending Disability	<input type="checkbox"/> Pending Workers' Compensation	Do you wish to supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> Other (Explain)	Is this absence due to a condition for which an FMLA Certification form is on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Hours Requested
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I have insufficient sick leave for the above request.
I request the following in lieu of sick leave:

Vacation Personal
 Compensatory Leave Without Pay

I certify that this request for leave form contains true and complete information.

Signature of Employee

Administrative Action

<input type="checkbox"/> Recommended <input type="checkbox"/> Not Recommended	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved
Supervisor Signature _____ Date _____	Appointing Authority Signature _____ Date _____

Remarks	Remarks
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