LEAVE REQUEST FORM

Employee Name:_____ Employee Number:_____

Department:_____ Date:_____

Leave Requested:

_____Annual _____Military _____FMLA

_____Compensatory _____Professional

_____Funeral _____Sick

_____Jury/Witness _____Unpaid

Dates for requested leave _____

_____

Employee Signature:_____

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Leave Approved_____ Leave Disapproved_____

State reason if disapproved:_____

_____

_____

Sign/Date:_____

Department Head