

**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)

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**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