Company Logo Here

Application For Leave

Employee Name:____Date Prepared:____________

Type of Leave Requested:

	Date/Days		Time/Hours		Total Hours
	From	To	From	To	
☐ Annual/Vacation					
☐ Sick Leave					
☐ Employee's Birthday					
☐ Emergency Annual					
☐ Without Pay					
☐ Administrative Leave					
☐ Bereavement					
☐ Other (please describe below):					

Description:

Employees requesting Medical or Pregnancy Disability Leave must attach a healthcare provider's statement verifying the need for leave and its beginning and expected ending dates. Any changes in this information should be promptly reported.

Employees returning from Medical or Pregnancy Disability Leave must submit a healthcare providers verification of their fitness to return to work (including any limitations on the employee's ability to perform the essential duties of the job).

Employee Signature:____ Date:____________

Executive Director/COO Approval: ______________________________________ Date:____________

Human Resources Sign off/Comments: