LEAVE REQUEST FORM

*All leave requests must be submitted a minimum of two weeks/14 days prior to requested day off

Employee Information	
Employee Name:	
Job Title:	Date:
Date(s) requested off:	
Return date:	
Total number of hour(s) requested off: _____ hours	

Type of Leave Requested (check one)	
☐ Vacation	☐ Maternity/Paternity (circle one)
☐ Sick	☐ Compensatory
☐ Bereavement	☐ Unpaid
☐ Other (please specify):	

Employee Signature:
Date: ____/____/____

Office Use Only	
Leave Granted? ☐ Yes ☐ No	Comments:
Administrator Signature:	
Date: ____/____/____	