APPROVAL OF LEAVE FORM

Employee	Employee ID Number	Date

EMPLOYEE USE

Approval is requested for leave as follows:

Beginning _____ _____
Time Date

Through _____ _____
Time Date

☐ ANNUAL LEAVE

☐ COMPENSATORY LEAVE
(requires board approval)

☐ ENFORCED LEAVE
(charged to sick leave)

☐ FAMILY LEAVE
(charged to sick leave)

☐ SICK LEAVE
I hereby certify that the above listed leave was due entirely to personal illness. During said period I was wholly unable to perform my official work or to be present at my post of duty.

Signature of Employee

OFFICIAL USE ONLY

Absence charged as follows:

☐ Annual Leave _____ Hours

☐ Comp Leave _____ Hours

☐ Enforced Leave _____ Hours

☐ Family Leave _____ Hours

☐ Sick Leave _____ Hours

☐ With Pay ☐ Without Pay

Recorded by _____

Employee Remarks

Signature of Supervisor

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

After three days absence due to illness a doctor's statement is required. This form or any statement signed by the physician or practitioner may be used.

_____ _____
Employee's Name Period Under Professional Care

Remarks _____

I certify that the above named individual was under my professional care for the period indicated above, and that his/her condition during this period made reporting to work inadvisable.

_____ _____
Signature of Physician or Practitioner Date